ATLANTIC RADIOLOGY
Pooler Imaging Center

Patient Registration

Patient Name: _____

Primary Address/ Billing Address: _____

Address Update:

_____

Primary Phone Numbers: _____

Email: _____

Emergency Contact: Name and Number

_____

If a minor, parent/guardian name and date of birth:

_____

MEDICAL INSURANCE/ ATTORNEY INFORMATION

Primary Insurance: _____

Policy ID: _____ **Policy Holder:**_____

Policy Holder DOB:_____ **Relationship to Patient:**_____

Secondary Insurance:_____

Policy ID:_____ **Policy Holder:**_____

Policy Holder DOB:_____ **Relationship to Patient:**_____

Attorney Name: (if applicable) _____

**A disc with images can be requested for any exam done. The first disc will be given at no charge. A fee will be charged for each additional disc.

The information provided above is accurate to the best of my knowledge.

Signature: _____