ADVANCED MRI OF THE BAHAMAS
#2 Building | Caves Village | West Bay St. | Nassau, Bahamas
TEL: (242)327-2604 | FAX: (242)327-2607

PATIENT REGISTRATION

PATIENT NAME: _____

RESPONSIBLE PARTY NAME: _____

ADDRESS: _____

P.O. BOX (Postal Address): _____

EMAIL ADDRESS: _____

PHONE: _____**BUS. PHONE**: _____**CELL PHONE**: _____

SEX: Male Female **BIRTHDATE:** Month_____ Day_____ Year_____ **AGE:** _____

WERE YOU INJURED ON THE JOB: Yes No **DATE OF INJURY:** _____

REFERRING PHYSICIAN NAME: _____

IS PATIENT: Married Single Divorced Other IS **PATIENT**: Employed Full-Time Student or Part-time Student

EMPLOYER NAME: _____

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INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE CO. NAME: _____

INS CO. ADDRESS: _____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER:_____

POLICY ID:_____ GROUP#:_____

POLCY HOLDER SEX: Male Female POLICY

BIRTHDATE: Month_____ Day_____ Year_____

SECONDARY INSURANCE:

INSURANCE CO. NAME: _____

INS CO. ADDRESS: _____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER:_____

POLICY ID:_____ GROUP#:_____

HOLDER SEX: Male Female

BIRTHDATE: Month_____ Day _____Year_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of Advanced MRI of the Bahamas at P.O. BOX SP 63142, #2 Building, Caves Village West Bay Street, Nassau, Bahamas for medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Advanced MRI of the Bahamas to release any information required in the course of my examination or treatment.

SIGNATURE: _____ **DATE:** _____