VALLEY MRI AND RADIOLOGY, INC.

STOCKTON (209)467-1000 **LODI (209)366-1000**

PATIENT REGISTRATION

Name:		Sex: Male Female
Mailing Address:		
City:	State:	Zip:
Phone:	Date of Birth:	
Cell Phone:	Social Security #:	
Employer:	Work Phone:	
Employer Address:	City:	
Email:	State:	Zip:

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment reminders, health bulletins, healthvault)

☐ YES ☐ NO

Spouse's/Partner's Name:			Sex: Male Female
Mailing Address:			
City:	State:	Zip:	
Phone:	Date of Birth:		
Cell Phone:	Social Security #:		
Employer:	Work Phone:		
Employer Address:	City:	State:	Zip:

RESPONSIBLE PARTY (Complete Only if Different From Patient or Spouse)

☐ Parent ☐ Guardian ☐ Other ______________________

Name:			
Address:		City:	
State:	Zip:	Phone:	
Employer:		Date of Birth:	
Address:		Social Security #:	
City:	State:	Zip:	Work Phone:

VALLEY MRI AND RADIOLOGY, INC.

EMERGENCY CONTACT

Name:		Phone:
Address:		City:
State:	Zip:	Relationship:

INSURANCE

Primary Insurance:	Secondary Insurance:
Subscriber:	Subscriber:
ID #:	ID #:
Group #:	Group #:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
Employer:	Employer:
Employer Phone:	Employer Phone:

Additional Insurance:	Subscriber:
ID #:	Group #:
Date of Birth:	Social Security #:
Employer:	Employer Phone:

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?

☐ ***YES*** ☐ ***NO***

DOI: __________________ ☐ **AUTO** ☐ **WORK** ☐ **OTHER _________________**

WORK COMP/AUTO INSURANCE:	
CLAIM#:	PHONE:
ADJUSTER:	
EMPLOYER(AT TIME OF INJURY):	

VALLEY MRI AND RADIOLOGY, INC.

PATIENT DEMOGRAPHICS

☐ **DECLINE**

Non-disclosure of Patient Demographics information: I hereby decline to provide my race, ethnicity, smoking status, and preferred language to Valley MRI And Radiology Inc. I understand that I have the ability to provide this information to Valley MRI And Radiology Inc., and upon disclosure, this information will be added to my patient record.

______________________________________ ____________________

Signature **Date**

RACE: ☐ American Indian ☐ Alaska Native ☐ Native Hawaiian
☐ Pacific Islander ☐ Asian ☐ White
☐ Black or African American

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

PREFERRED LANGUAGE: ☐ English ☐ Indian ☐ Chinese ☐ French
☐ Spanish ☐ Japanese ☐ Russian ☐ Other __________

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Legal Separation ☐ Unknown
☐ Single ☐ Widowed ☐ Other ____________________

SMOKING STATUS: ☐ Smoker (Everyday) ☐ Smoker (Occasional)
☐ Non-Smoker ☐ Former Smoke

______________________________________ ________________________

PATIENT SIGNATURE **DATE**