VALLEY
MRI & RADIOLOGY, INC.

PATIENT REGISTRATION

Name:		**Sex: Male Female**
Mailing Address:		
City:	**State:**	**Zip:**
Phone:	**Date of Birth:**	
Cell Phone:	**Social Security #:**	
Employer:	**Work Phone:**	
EMERGENCY CONTACT INFORMATION		
Contact Name:	**Phone:**	**Relationship:**

Would you be interested in having communications sent to you via your e-mail address? (Examples: HealthVault-access to your imaging results)

☐ **YES** ☐ **NO**

Email Address:

If patient is a minor, please provide parent/guardian information (complete only if different from patient or spouse)

☐ **Parent** ☐ **Guardian** ☐ **Other** _____

Name:		**Date of Birth:**
Address:		**City:**
State:	**Zip:**	**Phone:**

INSURANCE

Primary Insurance:	**Secondary Insurance:**
Subscriber:	**Subscriber:**
Date of Birth:	**Date of Birth:**
Social Security #:	**Social Security #:**
Employer:	**Employer:**

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**