REM DIAGNOSTICS, INC.
PATIENT REGISTRATION & INSURANCE INFORMATION

PLEASE PRINT & COMPLETE ENTIRE FORM

PATIENT INFORMATION

Name_____
First Middle Last

Street Address _____City/State/Zip_____

Mailing Address_____City/State/Zip_____

Home Phone #_____Cell/Other Phone#_____

Birthdate_____ Age_____Sex: M F Social Security #_____

Driver's License #_____ Status: Single Married Widowed Divorced

Spouse's Name_____ Birthdate_____ Social Security #_____

Spouse's Employer_____ Work Phone_____

Address_____ City/State/Zip_____

Person to notify in case of emergency_____Phone #_____

Referring Physician_____ Family Physician_____

EMPLOYMENT INFORMATION

Patient's Employer_____Occupation_____

Address_____City/State/Zip_____

Work phone #_____ May we call you at work? Yes No

INSURANCE INFORMATION

Primary Insurance_____ Secondary Insurance_____

Subscriber's Name_____ Subscriber's Name_____

ID #_____ ID #_____

Group #_____ Group #_____

Claims Address_____ Claims Address_____

City/State/Zip_____ City/State/Zip_____

_____ _____
Date Signature