

UNIVERSITY DIAGNOSTIC INSTITUTE REGISTRATION FORM

Patient name: _____

If minor, guardian name: _____

Date of birth: ____ / ____ / ____ **Social Security #:** _____

Home phone #: _____ **Work #:** _____

Email Address: _____

Patient address: _____

City **State** **Zip**

Employer: _____

If minor, guardian's employer

Spouse's employer: _____

Primary Insurance Company Name: _____

Address: _____

City **State** **Zip**

ID #: _____ **Group #:** _____

Secondary Insurance Company Name: _____

Address: _____

City **State** **Zip**

ID #: _____ **Group #:** _____

Authorization to pay benefits to physicians: I hereby authorize payment directly to University Diagnostic Institute for medical benefits. I understand that the benefits are limited to my insurance contract. I give permission to release information including the diagnosis and records pertaining to my treatment.

Signature: _____ **Date:** _____