MDX Imaging Center
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Tamuning, Guam 96913
Ph: 671-648-6390
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REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME / MIDDLE NAME	Mx.	MARITAL STATUS
		☐ Mr. ☐ Miss ☐ Ms ☐ Mrs.	☐ Single ☐ Married ☐ Widowed ☐ C-Law

SOCIAL SECURITY NUMBER	E-MAIL ADDRESS	BIRTHDATE	AGE	SEX

MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE	CELL PHONE

PAYER / INSURANCE SUBSCRIBER'S INFORMATION

PAYER'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

MAILING ADDRESS	CITY	STATE	ZIP CODE	CELLPHONE NUMBER

PATIENT'S RELATIONSHIP TO SUBSCRIBER	☐ Self ☐ Spouse Child ☐ Other _____

PRIMARY INSURANCE	POLICY NUMBER/MEMBER NUMBER	SUBSCRIBER'S NAME

SECONDARY INSURANCE	POLICY NUMBER/MEMBER NUMBER	SUBSCRIBER'S NAME

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	HOME PHONE	WORK PHONE	CELL PHONE

I authorize the use and disclosure of my protected health information as indicated below.
I understand that my protected health information is health information collected from me for the provision of my healthcare.
This document authorizes the use and disclosure of protected health information relating to ALL HEALTH CARE SERVICES provided by MDX Imaging Center including but not limited to

completion of my medical claims and release copies of medical records for the course of my examination or treatment.
Furthermore, **I direct any entity receiving a copy of this form to release original copies of all medical records and any other information relating to my care as requested by MDX Imaging Center.**

REFERRING PHYSICIAN

NAME OF FIMILY MEMBER/FRIEND

OTHER PHYSICIAN/SPECIALIST

NAME OF FAMILY MEMBER/FRIEND

Patient understands the following:

1. I understand that disclosed protected health information may be subject to re-disclosure by MDX Imaging Center and no longer protected by Federal law.
2. I understand that I may revoke this authorization at any time through a written notification to MDX Imaging Center.
3. I understand that this revocation will not be effective for information that MDX Imaging Center has already used or disclosed.
4. I had reviewed and understood the contents and purpose of the authorization for release of protected health information.
5. Photocopy of authorization is valid as original.
6. I understand the results from my exam today will be forwarded to my physician listed above.
7. I understand the results from my exam today will be released to my physician.

PATIENT'S SIGNATURE: _____ **Date:**_____