



iCare Diagnostic Imaging, LLC
 2781 Freeway Blvd
 Suite 160
 Brooklyn Center, MN 55430

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Last name:		First:	Middle:
Social Security no. - -	Marital status (circle one) Single / Married / Divorce / Widowed	Age:	Sex (circle one) Male Female
Home address:		Home phone no.: ()	
Is the patient a minor? (circle one) Yes No	If yes, parent/guardian name:		
Emergency contact (name and phone #):			

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Insurance Company name:	Primary insured:	Primary insured's address (if different):	
Relation to patient:	DOB:	Group #	Policy #
Secondary Insurance company name:	Group#	Policy #:	

AUTO INJURY / WORKERS COMPENSATION			
Type of accident:	Work Related (circle one):	Yes No	Date of injury
Claim # :	Adjuster:	Phone # :	
Employer at time of injury :		Work phone :	
Employer address:			

ATTORNEY INFORMATION	
Type of accident:	Date of accident:
Attorney name:	Phone: ()
Attorney Address :	

Patient Signature	Relation to patient:	Date:
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