SOLIS Mammography

For Office Use Only: Place Patient Label Here

Registration Form

*Fields marked * are required*

Patient Information

First Name:*_____ Middle:*_____ Last Name:*_____

Date of Birth: *_____

Address: *_____City: *_____

State: *_____Zip Code: *_____Email:_____

Full Social Security Number: *_____Preferred Language:_____

Race:*_____Ethnicity:*_____

Phone Numbers*

Contact Preference: Mobile / Home / Work Home:_____

Mobile:_____ Work: _____

Name of Emergency Contact: _____

Emergency Number: _____ Relationship to Emergency Contact: _____

Are you willing to accept results left on voicemail? *_____

Primary Insurance

Plan Name: _____

Policy Holder Name: _____

Policy Holder DOB: _____

ID#:_____Group#: _____

Secondary Insurance

Plan Name: _____

Policy Holder Name: _____

Policy Holder DOB: _____

ID#:_____Group#: _____

Is this Patient Covered by Insurance? Yes or No

Physician(s) _____

Referring Physician: *

Send Copy to Physicians: _____

Advance Directives

Do you currently have Advance Directives? **Yes or No**

Would you like information on Advance Directives? **Yes or No**

Solis can deliver your confidential results electronically. Circle 'I Agree' below and ensure you have provided an email address and cell phone number above if you would like to benefit from this.

I agree / I do not agree to allow electronic communications via email relating to my appointment, results and reminders e.g. appointment confirmation email, 1-week appointment reminder, or results alert.

I agree / I do not agree to allow electronic communications via text messages relating to my appointment, results and reminders e.g. appointment confirmation email, 1-week appointment reminder, or result alert.

Consent to Medical Treatment - I consent to the medical and/or surgical care as deemed necessary or advisable in the judgment of my physician or other provider. This may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, or other services rendered.

Assignment of Benefits - I authorize Solis Mammography to bill all insurance payers (e.g., private health insurance, Medicare, Medicaid, and any other health insurance payers) that cover me for any services provided to me in the past or future by Solis. I request that payment of authorized insurance benefits be made on my behalf to Solis, as my designated authorized representative, for any services provided to me in the past or future by Solis, and I hereby assign such payment to Solis. I consent to be contacted at any of the phone numbers I have provided, either past or future, in connection to my account regarding services rendered and possible related financial obligations. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. ***I understand that I am financially responsible for all charges, whether or not paid by insurance. A claim will be filed for services provided, but coverage differs by plan and cannot be guaranteed***. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

Receipt of Privacy Notice - I have received a copy of Solis Mammography's Notice of Privacy Practices, which describes how my health information may be used and disclosed by Solis as permitted under federal and state law.

_____ Date: _____

Signature of Patient or Patient Representative (state relationship to patient)