Transmed Inc.
The Ultrasound Professionals

Patient Registration

Date _____ Exam _____

Exam Reason_____ Patient ID #_____

Section I. Patient Information **Please Print Carefully**		
Patient's Last Name (Use legal name)	First Name	Middle Initial
Patient's Mailing Address (No. & Street/PO Box) (City) (State) (Zip Code)		
Patient's Date of Birth	Patient's Social Security Number	Marital Status (Circle One) S M W Sep D
Patient's Sex ○ Male ○ Female	Nickname/AKA/Maiden Name	Race/Ethnicity
Daytime Phone Number	Cell Phone Number	Patient's E-mail Address
Guarantor/Person Responsible for Patient's Account	Relationship to Patient	
Ordering Physician/Provider	Ordering Phys Phone # Ordering Phys Fax #	
Section II. Patient Employer Information		
Patient's Employment Status (Circle One) Employed Self-Employed Unemployed Disabled Retired PT Student FT Student		
Employer Name		Employer Telephone Number
Patient's Occupation		
Section IV. Insurance Information – *Please provide card(s) to receptionist*		
Medicaid # (If Applicable)	Medicare # (If Applicable)	
Primary Insurance Company Name and Subscriber Name (*if different from Patient*)		
ID #	Group #	Telephone #
Secondary Insurance Company Name and Subscriber Name (*if different from Patient*)		
ID #	Group #	Telephone #
Tertiary Insurance Company Name and Subscriber Name (*if different from Patient*)		
ID #	Group #	Telephone #
List any Other Insurances for Patient -		
Section V. Emergency Contact Information		
Emergency Contact Name	Relationship to Patient	
Contact Address (Number & Street/PO Box) (City) (State) (Zip Code)		
Day Time Phone #	Cell Phone #	Work Phone #

I have reviewed and confirm that the above information I have provided is up to date and accurate to the best of my knowledge.

_____Date _____

Signature of Patient, Parent or Guardian

_____ _____

Print Name of Person signing if other than Patient Relationship

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