

## CMI Patient Registration Form

Patient's Last First Middle Legal Name			Also Known As: (maiden, nicknames, etc.)		
Street Address Apt. #					
City State Zip Country					
Mailing Address (if different than street address)					
Home Phone #		Cell Phone #		Pager #	
Soc. Sec. #	Driver's License # State		Date of Birth	Marital Status	Sex
Patient's Employment Status (circle one) Full-time Part-time Retired Not Employed					
Patient's Occupation			Employer		
Employer's Address			City	State	Zip Code
Work # (include extension)					
<b>Physician who ordered the test (must have First and Last name)</b>				<b>Physician's #</b>	
<b>Family or Primary Physician (must have First and Last name)</b>				<b>Physician's #</b>	
<b>Emergency Contact</b>					
Name Last		First		Relationship	
Daytime Phone #		Evening Phone #		Pager # /Cell Phone #	
<b>Financial Information -- If you have insurance card(s) with you, you can omit this section</b>					
<b>Primary Insurance</b>			<b>Secondary Insurance</b>		
Insurance Company Name			Insurance Company Name		
Insurance Company's Telephone #			Insurance Company's Telephone #		
Address to mail claim			Address to mail claim		
City State Zip			City State Zip		
Name of Insured		Group #	Name of Insured		Group #
Policy #			Policy #		
Beginning Coverage Date		HMO or PPO	Beginning Coverage Date		HMO or PPO
What is your co-pay amount?			What is your co-pay amount?		