



At St. Joseph's Imaging we strive to provide our patient's with the most convenient and confidential means of scheduling appointments. We understand it is difficult in many instances to speak freely from the work place or you simply are not available when we are to schedule your exams.

Please supply us with the following information

**Your name**

**Date of birth**

**Referring physician**

**Exam(s) you need to schedule**

**If you have had this exam before and it was not with us, where was it done**

**Which SJI location would you would like to go to**

**Which day of the week and time of day are best for you**

**What insurance you have.**

**If you would like your results sent to any other doctors**

**Send this information in an email to [lynnw@sjia.com](mailto:lynnw@sjia.com)**

Please be advised you will still need a written order or prescription from your doctor prior to having the exams performed.

You will receive a response from our scheduling department within 24 hours Monday through Friday. We will respond Monday morning to emails received after business hours on Friday through Sunday evening.

Thank you for choosing SJI for your Imaging needs. We look forward to seeing you at your appointment.



## PRE-REGISTRATION FORM

**PLEASE PRINT**

Date of appointment: \_\_\_\_\_

Patient last name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Guarantor if patient is a minor: \_\_\_\_\_

Address if different from patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of primary insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

Name of insured person: \_\_\_\_\_

Name of secondary insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Name of insured person: \_\_\_\_\_

### **Please provide the actual cards upon arrival.**

Is this visit related to a motorvehicle accident or work-related injury: If so, name and address of compensation carrier or car insurance carrier:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Policy/compensation case number: \_\_\_\_\_

Date of injury or accident: \_\_\_\_\_

Which of our six locations will you be going to? \_\_\_\_\_

PLEASE FAX YOUR COMPLETED FORM TO THE OFFICE YOU WILL BE GOING TO

North Medical Center	(315) 452-2559
Northeast Medical Center	(315) 329-7559
Syracuse	(315) 475-9518
Camillus	(315) 631-6559
Baldwinsville	(315) 635-6816
Fulton	(315) 593-1542