DATE: ____________________

PATIENT INFORMATION
(Please Print/ Complete Entire Form)

Patient's Last Name ____________________ First ____________________ MI _____ Sex _____

Date of Birth ____/____/_____ SS# ______-______-______ Home Phone # ____________________

Home Address: ____________________ City ________ State ________ Zip ________

Employer's Name ____________________ Phone# ____________________

Employer's Address ____________________ City ____________ State ________ Zip ________

Spouse's Name ____________________ MI __ Sex ___ DOB ________ SS# ______-______-______

Spouse's Employer ____________________ Phone# ____________________ Ext. ________

Address ____________________ City ____________ State ________ Zip ________

In Case of Emergency Contact (name, address, phone#) ____________________

____________________ Relationship ____________

Referring Physician ____________________ Phone # ____________________

Primary Care Physician ____________________ Phone # ____________________

PRIMARY INSURANCE

Insurance Carrier ____________________ ID# ____________________ Group# ____________________

Address ____________________ City ____________ State _____ Zip ______ Phone# ____________

Insured's Name ____________________ DOB ____________ SS# ______-______-______

Authorization/Referral# ____________________

SECOND INSURANCE

Insurance Carrier ____________________ ID# ____________________ Group# ____________________

Address ____________________ City ____________ State _____ Zip ______ Phone# ____________

Insured's Name ____________________ DOB ____________ SS# ______-______-______

Authorization/Referral# ____________________

ACCIDENT INFORMATION

Worker's Compensation Date of Loss: ____________________ No-Fault Date of Loss ____________

Other Date of Loss ____________________ Claim# ____________________

Attorney Name ____________________ Phone # ____________________

Adjustor Name ____________________ Phone# ____________________

Insurance Company Name and Address: ____________________

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Medicare Signature on File: Request that payment of authorized Medicare benefits be made on my behalf, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable to related services.

I HEREBY AUTHORIZE DOCTORS RADIOLOGY CENTER to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payment for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature ____________________ Date ____________________