Acct. # *(For Office Use)*_____ DR #_____ WIC_____ Med._____ DPW_____ Priv._____ Rehab._____ Liab._____

Date_____ **Patient's Phone # (Home)**_____ **(Work)**_____ **(Cell)**_____

Patient's Name_____ Age_____ Sex_____ Race_____
Last First Middle

Birthdate_____ Social Security #_____ Spouse's/Parents Name_____

Mailing Address_____ City_____ State_____ Zip_____

Street Address_____ City_____ State_____ Zip_____

Nearest Relative (not living with you)_____ Phone #_____ Relationship_____

Address_____ City_____ State_____ Zip_____

What Doctor Referred You to Our Office_____
Last First Address

Family Physician_____
Last First Address

Person/Guardian Responsible For Patients Bill_____ **Relationship**_____

Address_____ Phone_____

Employer_____ Address_____ Phone_____
Of Responsible Party

Hospital of Choice_____ **Imaging Center of Choice**_____

INSURANCE INFORMATION

Medicare #_____ (If Covered By Medicare) ❑ PRIMARY ❑ SECONDARY

Welfare #_____ (If Covered By Welfare) ❑ PRIMARY ❑ SECONDARY

INSURANCE – GROUP OR PRIVATE (Circle One) ❑ **PRIMARY** ❑ **SECONDARY**

Name of Insured_____ S/S #_____ DOB_____ P.C.P._____

Name of Employer_____ Ref. #_____

Address of Employer_____ Co-Pay Amt._____

Name of Insurance Company_____ D.O.I._____

Address of Insurance Company_____

Policy Number_____ Group Number_____

Relationship to Subscriber_____

NSURANCE – GROUP OR PRIVATE ❑ **SECONDARY**

Name of Insured_____ S/S #_____ DOB_____

Name of Employer_____

Address of Employer_____

Name of Insurance Company_____

Address of Insurance Company_____

Policy Number_____

Relationship to Subscriber_____

State_____

WORKMEN'S COMPENSATION – LIABILITY Claim #_____

Occupation At Time Of Injury_____ Bodypart_____ D.O.I._____

Name of Employer_____ Phone #_____

Address of Employer_____

Compensation Insurer of Employer_____ Phone #_____

Compensation Insurers Address_____ Phone #_____

Name of Attorney (If Applicable)_____

VERIFICATION INFORMATION ***(For Office Use)*** Claim #_____

Phone #_____

Person You Spoke To_____ By_____

Title_____