

Today's Date:				PCP:				
<b>PATIENT INFORMATION</b>								
Last Name:		First Name:		Middle Initial:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss. <input type="checkbox"/> Ms.	Marital Status:
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name):		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:				City:		State:	Zip:	
Occupation:			Employer:			Employer Phone No.:		(    )
Referred to Diagnostic Radiology by (please check one):				<input type="checkbox"/> Dr.:		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to work/home		<input type="checkbox"/> Internet/Directory	<input type="checkbox"/> Other:			
Other family members seen here:								
<b>INSURANCE INFORMATION</b>								
<i>(Please give your insurance card to the receptionist)</i>								
Person responsible for bill:		Birth date: / /		Address (if different):		Home Phone No.:		(    )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:			Employer:			Employer Phone No.:		(    )
Is this person covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance:								
Secondary insurance:				<input type="checkbox"/> Welfare (please provide coupon)		<input type="checkbox"/> Other		
Subscribers name:		Subscribers SSN:		Birth date: / /		Group No:	Policy No:	Co-Payment: \$
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscribers name:			Group No:	Policy No:	
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>IN CASE OF EMERGENCY</b>								
Name of relative or friend (not living at same address):			Relationship to patient:			Home Phone No.:	Cell/Work Phone No.:	
The above information is true and to the best of my knowledge. I authorize my insurance benefits be paid directly to Diagnostic Radiology. I understand that I am financially responsible for any balance. I also authorize Diagnostic Radiology or my insurance company to release any information required to process my claims.								
_____ Patient/Guardian Signature						_____ Date		