Patient Information

Name (First, M.I., Last)____

Address:______________________________**(City, State, Zip)**______________________

Date of Birth:______________**Age:**________**Social Security #:**______________**Sex (M/F)**_______

Married/Single/Other Responsible Party______________________**Relationship:**______________

Phone #:___________________**Cell #:**_____________________**Work #**______________________

Email Address:____

Reason for today's visit?____

Have you had any scans/imaging/x-rays in the past 6 months? Yes / No

Location of imaging center: Northside Hospital / Medica Forsyth / MRI and Imaging of GA:
____

In case of an emergency, who should we notify?_________________**Relationship:**______________

Address:_______________________________________**Phone #:**______________________

Primary Care Physician:______________________________**Pharmacy Phone #**______________

DOES YOUR INSURANCE COMPANY REQUIRE A REFERAL BEFORE YOU CAN BE SEEN? ________DO YOU HAVE AN HMO? _____________

Primary Insurance

Insurance Company:__________________________**HMO / PPO / POS / Indemnity**
Insured's Name:__________________________**Insured's Employer:**__________________________
Insurance Phone #:________________________**Policy #:**__________________________________

Co-pays, deductibles, and any other patient responsibility fees are due when services are rendered. If you have any questions about fees, please check with us prior to being seen. Insurance will be filed by our office as a courtesy and does not constitute a contract between the physician and insurance company for payment of your services. By signing this form, you agree to these terms.

___________________________________ ____
Patient Signature / Authorized Guardian **Date**