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

Address:_____

Date of Birth:_____Age:_____Social Security #'s_____Sex (M/F)____

Phone #:_____Cell #:_____Work #:_____

Email Address:_____

Reason for today's visit?_____

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

Location of Imaging Center: Northside Hospital / American Health Imaging:

In case of Emergency, who should we notify? _____Relationship:_____

Address:_____Phone #'s:_____

Primary Care Physician:_____ Phone #:_____

Pharmacy:_____ Pharmacy #:_____

DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL 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 #:_____

SECONDARY 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