



PET/CT CT MRI DEDICATED BREAST MRI DIGITAL MAMMOGRAPHY BONE DENSITY ULTRASOUND

PATIENT INFORMATION

FOR OFFICE USE

TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE INTL. _____ AGE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ E-MAIL ADDRESS _____

DATE OF BIRTH _____ SEX _____ MARITAL STATUS _____

SOCIAL SECURITY # _____ EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE _____

REFERRING PHYSICIAN _____ CITY _____ STATE _____

DO YOU HAVE ALLERGIES (IF YES, PLEASE LIST) _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE# _____

PRIMARY INSURANCE NAME _____

NAME OF POLICY HOLDER _____ POLICY # _____

SECONDARY INSURANCE NAME _____

NAME OF POLICY HOLDER _____ POLICY # _____

RESPONSIBLE PARTY FOR BILL (LEAVE BLANK IF SAME AS ABOVE)

LAST NAME _____ FIRST NAME _____ MIDDLE INTL. _____ AGE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ SEX _____ MARITAL STATUS _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

AUTHORIZATION TO FILE INSURANCE CLAIMS AND OBTAIN OR RELEASE INFORMATION REQUIRED FOR PATIENT CARE OR BILLING PURPOSES

I AUTHORIZE ANGEL WILLIAMSON IMAGING CENTER TO OBTAIN OR RELEASE ANY INFORMATION REQUIRED FOR PATIENT CARE OR BILLING, TO FILE INSURANCE CLAIMS, AND TO RECEIVE PAYMENTS MADE FOR SERVICES RENDERED.

I UNDERSTAND THAT INSURANCE IS FILED AS A COURTESY, AND THE PATIENT OR GUARANTOR REMAINS RESPONSIBLE FOR PAYMENT.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF GUARANTOR _____ DATE _____
