## WELCOME TO DIAGNOSTIC IMAGING, P.C.

We are pleased to serve you and hope your experience will be as pleasant as possible. The following information is designed to answer some questions you may have about your visit today. Please read, then complete the remainder of the front and back of this page.

### TEST RESULTS

We appreciate your desire to know the results of your test as soon as possible. Many of our referring doctors prefer to have the written final report of your imaging study along with all your other test and lab reports, if any, before they discuss the findings with you. Therefore, we ask that you follow the instructions given to you by your physician's office for obtaining the results of our studies. If your condition requires more immediate attention, we are sure your doctor will contact you. We appreciate your cooperation and are sure your physician does as well.

### BILLING AND INSURANCE CLAIMS

We are pleased to handle all of your insurance claims for your visit. Your statement will include the fee for testing and interpretation.

## PATIENT INFORMATION

**PLEASE PRINT**

NAME LAST _____ FIRST _____ MI _____ AGE _____

ADDRESS _____ APT. # _____ CITY _____ STATE _____

ZIP _____ PHONE HOME (  ) _____ - _____ CELL (  ) _____ - _____

SOCIAL SECURITY #_____ DATE OF BIRTH _____ / _____ / _____

EMAIL ADDRESS_____

SEX: M / F MARTIAL STATUS: SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____

**HAVE YOU BEEN HERE BEFORE?** _____ **IF SO, UNDER WHAT NAME** _____

NAME OF EMPLOYER OR
IF RETIRED NAME OF COMPANY _____OCCUPATION_____

EMPLOYERS ADDRESS _____ CITY _____

STATE _____ ZIP _____ EMPLOYER'S PHONE (  ) _____ - _____

REFERRING PHYSICIAN _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE (  ) _____ - _____

## SPOUSE or PARENT INFORMATION

NAME LAST_____ FIRST _____ MI _____ AGE _____

ADDRESS _____ APT. # _____ CITY _____ STATE _____ZIP_____

PHONE HOME (  ) _____ - _____ CELL (  ) _____ - _____ SEX: M / F OCCUPATION_____

SOCIAL SECURITY # _____ DOB _____ / _____ / _____

EMPLOYER'S NAME_____ EMPLOYER'S ADDRESS: _____

CITY _____STATE _____ ZIP _____ EMPLOYER'S PHONE (  ) _____ - _____

RELATIONSHIP TO PATIENT: SPOUSE _____ PARENT _____ GUARDIAN _____ LEGAL REP _____ OTHER_____

PATIENT NAME _____

## IN CASE OF EMERGENCY NOTIFY

NAME _____ ADDRESS _____

PHONE (  ) _____ - _____ RELATIONSHIP TO PATIENT _____

## ACCIDENT / WORKER'S COMP INFORMATION

IS THIS VISIT DUE TO AN ACCIDENT? YES ____ NO ____ CAR ACCIDENT _____ WORK INJURY _____ OTHER _____

DATE OF ACCIDENT _____ / _____ / _____ LOCATION OF ACCIDENT_____

NAME OF PERSON TO CONTACT TO VERIFY COVERAGE _____

PHONE (  ) _____ - _____ POLICY or CLAIM # _____

ADDRESS TO MAIL CLAIM_____
STREET / P.O. BOX CITY ZIP

## INSURANCE INFORMATION

**PRIMARY INSURANCE**

IT IS NOT NECESSARY TO COMPLETE THE PRIMARY INSURANCE SECTION
IF THE PATIENT PRESENTS THEIR INSURANCE CARD FOR DIAGNOSTIC IMAGING TO OBTAIN A COPY.

COMPANY NAME _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE (  ) _____ - _____

GROUP NUMBER _____ POLICY NUMBER _____

INSURED'S NAME _____ EMPLOYER _____

EMPLOYER ADDRESS _____ PHONE (  ) _____ - _____

INSURED'S DATE OF BIRTH _____ / _____ / _____ SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT SELF_____ SPOUSE _____ PARENT _____ GUARDIAN _____ OTHER _____

**SECONDARY INSURANCE**

COMPANY NAME _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE (  ) _____ - _____

GROUP NUMBER _____ POLICY NUMBER _____

INSURED'S NAME_____

INSURED'S DATE OF BIRTH _____ / _____ / _____ SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT SELF_____ SPOUSE _____ PARENT _____ GUARDIAN _____ OTHER _____