PATIENT INFORMATION

Last Name ______ First Name ______ M.I. ____ Sex ______

Street Address ______ Apartment/Unit # ______

City ______ State ______ Zip Code ______

Home Phone ______ Mobile Phone ______

Date of Birth ______ Social Security # ______ Marital Status ______

Employer ______ Work Phone ______

Emergency Contact Name ______ Phone ______

Email Address ______ Referred By ______

FOR OFFICE USE ONLY

INSURANCE (PRIMARY)

Insurance Plan ______

ID ______

Group ______

Plan Subscriber ______

Relationship to Subscriber ______

Subscriber’s DOB ______

Subscriber’s Employer ______

INSURANCE (SECONDARY)

Insurance Plan ______

ID ______

Group ______

Plan Subscriber ______

Relationship to Subscriber ______

Subscriber’s DOB ______

Subscriber’s Employer ______

WORK COMP / ATTORNEY / NO FAULT / PERSONAL INJURY

Company ______

Adjuster ______ Phone Number ______

Mailing Address ______ PO Box/Suite# ______

City ______ State/Zip ______

Claim # ______ DOI ______

Employer for Work Company Injury ______ Phone # ______

Subscriber’s Employer ______ Subscriber’s Employer ______

Disclaimer & Signature

I hereby request that payment of insurance benefits be made directly to Professional Imaging, LLC, on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to service(s) rendered to me or dependent. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to make arrangements for prompt payment of my bill.

I have received and or been offered the Notice of Privacy Practices. I hereby authorize Professional Imaging, LLC roteted Health Information (PHI) contained in my medical record to my treating physician, insurance company, attorney, and immediate family on behalf of myself and/or my dependents for the purpose of Treatment, Payment and Operations (TPO).

I authorize any physician or other health care providers participating in my treatment to provide copies of any medical records regarding me to each other.

______ Signature ______ Date