

Pro Imaging Patient Information

Today's Date: _____ Referring Physician: _____

Confidential Record Information contained here will not be released unless you have authorized us to do so

Name: _____ M / F _____
Last First Middle Initial Sex

Address: _____
Street City State Zip Code

Birth Date: _____ Marital Status: _____ Age: _____ Occupation: _____

Soc.Sec.# _____ Home Phone: _____ Work Phone: _____

E-mail Address: _____

Employer's Name _____ Address: _____

Spouse's / Guarantors Name: _____ Soc. Sec.#: _____ Birth Date: _____

Spouse's / Guarantors Employer & Address: _____

Spouse's / Guarantors Telephone #: _____

Name on Primary Insurance Card: _____ ID#: _____

Name on Secondary Insurance Card: _____ ID#: _____

Person to notify in case of emergency (not living with you): _____

Relationship of above: _____ Phone #: _____

Address of above: _____

Is this test being performed because of a condition related to :
1. Employment? Yes / No
2. Auto Accident? Yes / No
3. Other Accident? Yes / No

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of information for insurance purposes and I authorize insurance companies to pay directly to this office the insurance benefits due for service rendered. I authorize the release of information to/by any physician requesting reports and/or films for continuity of medical care.

In the event of insurance payment being denied by the insurance company, the payment for services will be my responsibility.

Please Note: Testing that is being performed today may be interpreted by another Physician. There will be a separate charge for this service.

Signed: _____ Date: _____
Patient/Representative/Legal Guardian