Advanced Imaging Center

Patient Information Sheet *(IF UNDER 18 YEARS OF AGE **MUST** BE COMPLETED BY PARENT/GUARDIAN)*

NAME _____ DOB_____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

HOME PHONE _____ SSA# _____ SEX _____

EMPLOYER _____ PHONE _____

RESPONSIBLE PARTY

NAME _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

ABOUT YOUR CONDITION

REASON FOR SCAN (CHECK ONE) ILLNESS _____ AUTO ACCIDENT _____ JOB INJURY _____

DATE OF ILLNESS/AUTO ACCIDENT/JOB INJURY _____

ATTORNEY'S NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____

PRIMARY INSURANCE INFORMATION

NAME _____ ID# _____

GROUP/POLICY # _____ PHONE _____

INSURED: _____ DOB _____ RELATIONSHIP _____

SECONDARY INSURANCE

NAME _____ ID# _____

GROUP/POLICY # _____ PHONE _____

INSURED: _____ DOB _____ RELATIONSHIP _____

It is understood and agreed that I the patient and/or responsible party (if minor) acknowledge and accept full responsibility for the charges for services rendered at Advanced Imaging Center. I also authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier of services rendered. **I am responsible for all co-pays, deductibles, non-covered services, and denied claims including, but not limited to, medical necessity.**

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____