

PATIENT INFORMATION

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| PATIENT'S NAME: | | SOCIAL SECURITY: | |
| ADDRESS: | CITY: | STATE: | ZIP: |
| HOME PHONE # : | SEX: | BIRTH DATE: | |
| REFERRING DOCTOR: | | | |
| EMPLOYER: | | EMPLOYER PHONE#: | |
| ADDRESS: | | | |
| EMERGENCY CONTACT | | PHONE #: | |

INSURANCE INFORMATION

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| INSURANCE : | TELEPHONE #: |
| ADDRESS: | |
| CITY, STATE & ZIP: | |
| INSURED'S NAME: | RELATION TO INSURED: |
| INSURANCE ID #: | GROUP #: |

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|-------------------|----------------------|
| INSURANCE: | TELEPHONE #: |
| ADDRESS: | |
| CITY, STATE, ZIP: | |
| INSURED'S NAME: | RELATION TO INSURED: |
| INSURANCE ID#: | GROUP#: |

WORKER'S COMPENSATION INFORMATION

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| INSURANCE: | DOI: | CLAIM #: |
| ADDRESS: | | |
| ADJUSTER: | | PHONE #: |

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| <p>ALL PATIENTS: I authorize you and your duly authorized agents to release information to my insurance carrier relative to any claim(s) I may incur. This permission is granted on my behalf for my lifetime. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. I hereby give permission for my Insurance Co. to pay Diagnostic Imaging Specialists, P.A. directly.</p> <p>Signature Of Patient: _____ Date: _____</p> | <p>MEDICARE PATIENTS ONLY: I authorize the holder of medical or any other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this Authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to Diagnostic Imaging Specialists, P.A. I understand this is a lifetime authorization to be used for this and any subsequent claims.</p> <p>Signature Of Patient: _____ Date: _____</p> | <p>I hereby give permission for my Insurance Company to pay Diagnostic Imaging Specialists, P.A. directly. In assigned cases the doctor agrees to the charge determination of the Medicare carrier as the full charge for covered services. The patient is responsible only for the deductible, co-insurance and non-covered services. The permission is granted on my behalf for my lifetime.</p> <p>Signature Of Patient: _____ Date: _____</p> |
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| COMMENTS: |
| ALLERGIES: |

| DATE | CPT | PROCEDURE | DX | CHARGE |
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| TOTAL CHARGES: |
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