DIAGNOSTIC RADIOLOGY, ULTRASOUND & BREAST CENTER, PC

PLEASE PRINT

CHART NO. ____________

DATE: ____________

SYMPTOMS:

REFERRING PHYSICIAN

PATIENT INFORMATION

PATIENT

LAST NAME	FIRST NAME	MIDDLE	NAME CALLED

STREET ADDRESS	APT #	CITY	STATE	ZIP

SOCIAL SECURITY #	DATE OF BIRTH	AGE	SEX	MARITAL STATUS	AREA CODE	HOME PHONE

EMPLOYED BY	OCCUPATION	BUS. PHONE

EMPLOYER'S ADDRESS

SPOUSE/PARENT NAME	SPOUSE/PARENT SOCIAL SECURITY #	EMPLOYED BY	EMPLOYER'S ADDRESS

BUSINESS PHONE	HOME PHONE	ADDRESS IF DIFFERENT FROM PATIENT	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

INSURANCE

INSURANCE COMPANY NAME: ____________

POLICY NUMBER: ____________ GROUP NUMBER: ____________

CLAIM MAILING ADDRESS ____________

(If Different from Insurance): Street/P.O. Box City State ZIP

CARDHOLDER'S NAME (If Different from Patient):: ____________

CARDHOLDER'S DATE OF BIRTH ____________ CARDHOLDER'S SSN: ____________

(If Different from Patient) (If Different from Patient)

CARDHOLDER'S EMPLOYER NAME, ADDRESS & PHONE ____________

(If Different from Patient)

****PLEASE BRING INSURANCE CARD(S) TO THE FRONT DESK, WE MUST PHOTOCOPY THEM****

As we file for many insurance companies and are providers for several HMO/PPO/managed care companies, please bring your insurance card(s) to the front desk for photocopying so we can file your insurance claim. You will be billed by statement for any applicable balance you may have.

If we are not filing your insurance, you will be given a copy of the paid bill to submit to your insurance company for reimbursement unless arrangements are made otherwise.

Preferred Method of Payment: Check ____________ Cash ____________ CreditCard ____________

GENERAL INFORMATION PLEASE READ

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Diagnostic Radiology, Ultrasound & Breast Center, PC, for services rendered. A photocopy of this authorization and assignment shall be considered as valid as the original.

Signature ____________ **Date** ____________

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