

Today's Date: _____ Referring Doctor: _____

Patient Name: _____ Maiden: _____

Date of Birth (DOB): _____ Sex: **M F** Marital status: Single Married Divorced Widowed

Mailing Address: _____
Street/P.O. Box City State Zip

SSN _____ Home Phone: (_____) _____ Work Phone: (_____) _____

Occupation: _____ Employer: _____ E-mail address: _____

Employer Address: _____

Name of spouse _____ Daytime phone number (_____) _____

Emergency contact - if different from spouse (name and phone): _____

Relative not living with patient (name and phone): _____

If someone other than patient will be responsible for the bill, please complete this section:

Name: _____ SSN: _____ DOB: _____ Relationship: _____

Address: _____ Phone: _____

Employer: _____ Work Phone: _____

Primary Insurance Coverage

Name of insurance company: _____ ID #: _____

Claims mailing address: _____
Street/P.O. Box City State Zip

Phone Number: (_____) _____ Group/Plan #: _____ Date effective: _____

Subscriber: _____ DOB: _____ Relation to patient: _____

Subscriber Employer/Address: _____
Company name Street/P.O. Box City State Zip

Secondary Insurance Coverage

Name of insurance company: _____ ID #: _____

Claims mailing address: _____
Street/P.O. Box City State Zip

Phone Number: (_____) _____ Group/Plan #: _____ Date effective: _____

Subscriber: _____ DOB: _____ Relation to patient: _____

Subscriber Employer/Address: _____
Company name Street/P.O. Box City State Zip

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION FOR RELEASE OF INFORMATION

I request that payment of authorized Medicare, Medigap or other insurance benefits be made on my behalf to Greater Houston Imaging, PA and/or _____ for any services furnished to me by one of the providers associated with that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA), its agents, and/or my Medigap or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

Signed: _____ Date: _____