

PATIENT INFORMATION

Name:	Gender:
Address:	Date of Birth:
City, ST, Zip Code	SSN:
Home Phone:	Marital Status:
Work Phone:	Primary Physician:
Cell Phone:	Emergency Contact Name:
Employer:	Relationship:
Email:	Phone:

INSURANCE GUARANTOR INFORMATION

Name:	Date of Birth:	
Address:	SSN:	
City, ST, Zip Code	Relationship:	
Home Number:	Employer:	Work Phone:

PRIMARY INSURANCE INFORMATION

Name:
Address:
City, ST Zip Code:
Insured ID:
Insurer Group ID:

SECONDARY INSURANCE INFORMATION

Name:
Address:
City, ST Zip Code:
Insured ID:
Insurer Group ID:

Is this visit work-related? If so, when? _____

Is this visit auto-accident related? If so, when? _____

Limited Authorization for Communications to the Patient Via Voice Mail: I authorize UNIV CTR IMG – Oaks/Suntree, to disclose the information I checked below by leaving it on the following message machine (s):

- | | |
|--|--|
| <input type="checkbox"/> My personal/home answering machine(____)_____ | <input type="checkbox"/> Cell Phone(____)_____ |
| <input type="checkbox"/> Work voice mail(____)_____ | <input type="checkbox"/> Email _____ |
| <input type="checkbox"/> Leave no messages | |

Description of information that may be disclosed:

- | | | |
|--|--|--|
| <input type="checkbox"/> Appointment Information (including prep information | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Medical Information |
|--|--|--|

In addition, you may disclose the above checked information, allow pick-up of your results and/or films to the following family members:

If your information is given to others as allowed in this form, Federal privacy laws may not protect it.

Expiration: This authorization will expire Fri, July 1, 2011

I hereby authorize UNIV CTR IMG – Oaks/Suntree to:

1. Provide treatment.
2. Furnish my insurance company(s) with all medical information requested
3. **By initialing, I am stating I am aware of UNIV CTR IMG – Oaks/Suntree’s Notice of Privacy Practices that was effective April 14, 2003 and I am able to obtain a copy at anytime. Initials _____**

The insurance information given by me is correct. I authorize and assign payment, under the terms of my policy, directly to UNIV CTR IMG – Oaks/Suntree. I understand that I am financially responsible for charges not paid by my insurance including deductibles and copays.

Signature _____
Signature of patient parent guardian

Date _____