

Please provide your insurance card and photo ID to the receptionist.

PRIMARY INSURED'S INFORMATION

Name: _____

Date of Birth: _____

Social Security #: _____

Driver's License #: _____

Relationship: _____ Phone: _____

Address: _____

City/St: _____ Zip: _____

INSURANCE INFORMATION

Insurance Type: (Circle One)

PPO HMO EPO POS

ASSIGNMENT OF BENEFITS:

I certify the above information is correct to the best of my knowledge. I understand that all deductible and co-pay amounts are due at time of visit. Also, I understand that I am financially responsible for all charges whether or not they are covered by insurance. Further I will be responsible for all collection and/or service charges if my account becomes past due. I hereby authorize payment directly to MRI Professionals.

Signature: _____ Date: _____

In Case of Emergency Phone: _____

PATIENT INFORMATION

Name: _____

Address: _____

City/St: _____ Zip: _____

Phone: _____ Alt Phone: _____

Date of Birth: _____ Age: _____

Driver's License #: _____

Social Security # _____

Marital Status: _____

Spouse's Name: _____

How did you hear about our office?

PATIENT'S EMPLOYER

Employer: _____

Occupation: _____

Address: _____

City/St: _____

Phone: _____

RELEASE OF INFORMATION:

I authorize the release of any medical or other information acquired in the course of my treatment to process insurance claims.

Signature: _____ Date: _____

In Case of Emergency Name: _____