

Patient Information Sheet

<b>Patient Information</b>	Patient Name: _____ Last                      First                      M.I.	Sex: _____ Date of Birth: ____/____/____ Age: ____ M/F                      Mon Day Year
	Address: _____ Street Number                      Apt. #	Home Phone (____) _____
	City                      State                      Zip	Work Phone (____) _____
	Social Security # _____	If Work Related, Injury Date: _____

Referring Doctor: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

<b>Financially Responsible Party</b>	Name: _____ Last                      First                      M.I.	Relationship to Patient _____
	Address: _____ Street Number                      Apt. #	Home Phone (____) _____
	City                      State                      Zip	Work Phone (____) _____
	Social Security # _____	Employer _____
Employer Address _____		City                      State                      Zip

<b>Insurance Information</b>	<b>Primary</b>	Insurance Co: _____	Address: _____
		Subscriber Name: _____	Relationship to Patient: _____
		Name of IPA or Medical Group: _____	
	<b>Secondary</b>	Insurance Co: _____	Address: _____
Subscriber Name: _____	Relationship to Patient: _____		

<b>Insurance Authorization</b>	<i>I hereby authorize and direct my Insurance carrier to pay directly to Open Advantage MRI any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan, regardless of Providers contractual agreement with Insurer.</i>
	<i>I authorize Open Advantage MRI to release to my insurance carrier any medical information necessary to process this claim.</i>
	<i>POINT OF SERVICE PATIENTS: I understand that I may be responsible for an additional co-pay if I have gone "Out of Network" (according to individual plan guidelines.)</i>
Authorized Signature: _____	Date: _____