Patient Information Sheet

Patient Information

Patient Name: ____
Last First M.I.

Address: ____
Street Number Apt. #

____
City State Zip

Social Security # ____________________________________

Sex: ______ Date of Birth: ____/____/____ Age: ____
M/F Mon Day Year

Home Phone (______) __________________________

Work Phone (______) __________________________

If Work Related, Injury Date: ____________________

Referring Doctor: ____________________________________ Phone Number (_____) ________________________

Financially Responsible Party

Name: ____
Last First M.I.

Address: ____
Street Number Apt. #

____
City State Zip

Social Security # ____________________________________

Relationship to Patient ________________________

Home Phone (_____) __________________________

Work Phone (_____) __________________________

Employer ____________________________________

____
Employer Address City State Zip

Insurance Information

Primary

Insurance Co: ____________________________________

Subscriber Name: ____________________________________

Name of IPA or Medical Group: ________________________

Address: ____________________________________

Relationship to Patient: ________________________

Secondary

Insurance Co: ____________________________________

Subscriber Name: ____________________________________

Address: ____________________________________

Relationship to Patient: ________________________

Insurance Authorization

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 authorize Open Advantage MRI to release to my insurance carrier any medical information necessary to process this claim.

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.)

Authorized Signature: ______________________________ *Date:* ______________________________