PATIENT INFORMATION

Date: _____ **Accident Related Injury Y / N** **Work Related Injury Y / N**

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____ Sex: [ ] Male [ ] Female

Address _____ City: _____ Zip: _____

Social Security Number: _____-_____-_____ Driver License #: _____

Phone: Home ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Professional Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Student - Part time / Full time

Employer Name: _____ Address: _____ City_____ Zip_____

Name of Person to be contacted in case of emergency: _____ Phone No: _____

Relationship to patient: _____

SPOUSE/PARENT INFORMATION:

Name: _____ Date of Birth _____ Sex: [ ] Male [ ]Female

Social Security Number: _____ Driver's License Number: _____

Employer: _____ Address: _____ City_____ Zip_____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company _____ Phone No: _____

Insurance Address: _____ City: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: Self____ Spouse _____ Parent_____ Insurance ID No: _____ Group No: _____

IPA/Medical Group: _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company _____ Phone No: _____

Insurance Address: _____ City: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: Self____ Spouse _____ Parent_____ Insurance ID No: _____ Group No: _____

IPA/Medical Group: _____

Financial Agreement: In consideration of services rendered, I, hereby, agree to pay all charges for all services provided by Millennium Imaging Medical Center in accordance with my medical insurance policy's current rates and terms and that all deductibles and copayment are due at the time of service.

Certification: I certify and understand that I personally completed this form and that all above information is true, correct and complete to the best of my knowledge.

Patient Signature: _____ Date: _____