

Patient Information Sheet For Advanced Imaging Associates

Patient Name: _____ Birthdate: _____ Sex: _____

Mailing Address: _____ SS#: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell #: _____ Work #: _____

Name of Primary Insurance Holder: If Patient is primary insurance holder write **SELF** below
 If holder in not the patient, please complete the following information:

Holder's Name: _____ Birthdate: _____ Sex: _____

Mailing Address: _____ SS#: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell #: _____ Work #: _____

Name of Secondary Insurance Holder: If Patient is secondary insurance holder write **SELF** below
 If holder in not the patient, please complete the following information. If no secondary, leave blank

Holder's Name: _____ Birthdate: _____ Sex: _____

Mailing Address: _____ SS#: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell #: _____ Work #: _____

Please answer the following questions:

Is this visit a result of an auto accident? _____ YES _____ NO

Is this visit a result of a workers compensation claim? _____ YES _____ NO

If "YES": Claim #: _____ ***** Date of Injury: _____

I, the undersigned certify the I (or my dependent) have insurance with _____ (ins. co.) and assign payment directly to Advanced Imaging Associates. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PATIENT/GUARDIAN SIGNATURE_____
Today's Date