

NEW PATIENT INFORMATION

*** PLEASE **PRINT**, AND PLEASE FILL OUT **BOTH SIDES** OF THIS FORM **COMPLETELY** ***

SECTION 1: ABOUT THE PATIENT

Soc. Sec. #

Last name:	First name:	M.I.:
Mailing Address:		
Zip Code:	City:	State:
Hm. Phone:	Wk. Phone:	Other #:
Birthdate:	Sex:	Race:
I am:		married single divorced separated widowed
I am employed:		full time part time retired none
I am a student:		full time part time

Who is the patient in relation to the person who has the insurance? spouse child parent
(please circle one)

Patient's employer is: Employer's phone:

Where can we leave messages regarding appointments, treatment, results, etc.? Home Work Other None
(please circle all that apply)

Calling restrictions:

In addition to the release of information for treatment AND/OR payment purposes, is there anyone else we can release medical information to other than you? NO YES (please fill out information on these people below):

Name	Relationship	Telephone
Name	Relationship	Telephone

Patient Signature: **Date:**

SECTION 2: ABOUT THE PARENT OR LEGAL GUARDIAN FINANCIALLY RESPONSIBLE FOR THIS PATIENT (NOT NECESSARILY THE SAME AS THE PERSON WHO HAS THE INSURANCE THAT COVERS THE PATIENT)

Is the person who has the insurance coverage for the patient the same person who is financially responsible? YES NO

If not, tell us about **the person who is financially responsible** for the patient:

Soc. Sec. #:	Date of Birth:	Sex: M F
Last Name:	First Name:	M.I.:
The person who is financially responsible is the patient's:		spouse child parent
This person's mailing address:		
City:	State:	Zip Code:
Hm. Phone:	Wk. Phone:	Other #:

***** PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM *****



SECTION 3: ABOUT THE INSURANCE COVERAGE

PRIMARY Insurance Company Name:

SECONDARY Insurance Company Name:

**SECTION 4: ABOUT THE PERSON WHO HAS THE INSURANCE COVERAGE
(NOT NECESSARILY THE SAME AS THE PERSON WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT)**

* * * Complete this section only if the patient is **NOT** the person who has the insurance * * *

About **the person who has the insurance**: Soc. Sec. #: Birthdate: Sex: M F

The person who has the insurance is the patient's: spouse child parent other

This person's last name: First: M.I.:

Mailing Address:

Zip Code: City: State:

Hm. Phone: Wk. Phone: Other #:

PLEASE READ AND SIGN THE FOLLOWING

The information submitted on this form is true and complete to the best of my knowledge.

I authorize the release of any medical information needed to process my insurance claim, and any payment of medical benefits to be submitted directly to Mountainview Medical Imaging.

I acknowledge the receipt of, or the availability of the Notice of Privacy Practices for Mountainview Medical Imaging.

If the patient or legal guardian is unable to sign, I verify that I am authorized to sign for consent to the treatment of this patient.

Patient (or Guardian) signature

Date

Relationship to patient if not patient signature