

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: _____ Cell#: _____

Birthdate: _____ Sex: _____ Rac _____ I am: married single divorced separated widowed

Email address: _____

I am a student: full time part time none I am employed: full time part time retired none

Who is the patient in relation to the person who has the insurance? self 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 _____
------------	--------------------	-----------------

How did you hear about us: (a.) my doctor (b.) a friend (c.) radio (d.) billboard (e.) print ad (f.) other

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