

Patient information

Insurance Information

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____ Age: _____ Sex: _____ Wt: _____

Home Phone: _____ Cell Phone: _____

Name of Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

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Cardholder's Last Name: _____ First: _____

Relationship to Patient: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

Cardholder's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

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INSURANCE INFORMATION:

Primary: _____ PreCert#: _____

_____ Policy: _____ Group: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary: _____ PreCert#: _____

_____ Policy: _____ Group: _____

Address: _____ City: _____ State: _____ Zip: _____

WORKMAN'S COMP:

Name of Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Injury: _____ Case#: _____ Adjuster: _____

WC Company: _____ Address: _____

REFERRING DOCTOR:

_____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Procedure	CPT Code	ICD Code	Total Fee	Amt Paid	Balance Due

I authorize Groton Open MRI to obtain or release any medical information including faxed reports. I also authorize my insurance company to pay Groton Open MRI directly for its services rendered. I realize that I am responsible for any co-payments, deductibles and all balances not paid by my insurance, and I agree to pay those monies to Groton Open MRI within 60 days unless otherwise authorized. If the account goes to collection for non-payment, I will be responsible for attorney fees.

Signature: _____ Date: _____