



PATIENT INFORMATION FORM

MRN: _____ Email Address: _____

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ Male Female Social Security No: _____

Mailing Address:

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____ Mobile Telephone: _____

Employer's Name: _____ Occupation: _____

Employer's Mailing Address: _____

WORKER'S COMPENSATION PATIENTS ONLY

Is today's visit due to an accident or injury? Yes No Date of injury: _____ Claim No: _____

Employer at Time of injury: _____ Employer's Phone No: _____

Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: YES NO If Yes, whom? _____

Primary Insurance Name: _____ Patient's Relationship to Policy Holder: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Sex: _____

Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: YES NO If Yes, whom? _____

Secondary Insurance Name: _____ Patient's Relationship to Policy Holder: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Sex: _____

REFERRING DOCTOR

Doctor's Name: _____ Exam(s) Requested: _____

IS PATIENT A MINOR Yes No If yes, please provide the following information: _____

Name of Responsible Party: _____ SSN: _____

Home Phone No.: _____ Work Phone No.: _____

Mailing Address (if different from patient): _____

EMERGENCY NOTIFICATION

Name: _____ Phone: _____ Relationship: _____

AUTHORIZATION

I confirm all the above information is correct and I authorize Reno Diagnostic Centers (RDC) and its billing company (Physicians Revenue Navigators) to submit any and all claims related to services provided to me by RDC today. I authorize the release of any medical or other information necessary to process this claim for services I receive today. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for all services rendered today. If I do not want my insurance company listed above billed for the services provided today, I understand it is my responsibility to ask for the "Insurance Billing Waiver Form" and to provide a completed, signed copy of this form to RDC at the time of service. I acknowledge that I am responsible for payment of all charges regardless of insurance coverage.

Signature of Patient or Guardian: _____ Date: _____