Reno Diagnostic Centers
When it has to be done right.

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: _____