



Patient Name: Last First Middle Initial DOB

Home Phone # Work Phone#

Street Address City State Zip Code

Social Security Number Reason for Exam/Diagnosis

How will you be paying today? () Check () Cash () Credit Card

Visit the result of an accident? () Yes () No (If Yes indicated one of the following :
() **WORK RELATED** () **AUTO ACCIDENT** () **OTHER**

PRIMARY INSURANCE INFORMATION ; This information is REQUIRED

Relationship to Patient:() Parent () Spouse () Employer () Other: _____

Insurance Company _____ Name of

Insured: _____

Insured's D/B: ___/___/___ Social Security Number ___/___/___ Sex () F () M

Insured's Address (if different from patient's):

Ph# _____

Employer: _____ Address: _____ Ph# _____

Insured's ID # _____ Group Policy# _____

Secondary Insurance Coverage:

Insurance Company : _____ Group Policy# _____

Insured's Date of Birth ___/___/___ Insured's ID # _____ Group Policy# _____

Address: _____ Effective Date _____

ASSIGNMENT OF INSURANCE BENEFITS

I certify that all of the information provided is correct to the best of my knowledge. I authorized payment of benefits from my insurance carriers (as detailed to IDI) to the Institute of Diagnostic Imaging and/or its affiliated physicians for services rendered this date. I understand that I will be billed directly for any remaining balance if my insurance deems said balance to be my responsibility.

INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Authorized Signature: _____ Date _____