

NORTHERN ARIZONA RADIOLOGY

Date: _____

Jacket No. _____

Patient Name:		SS#			
DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Marital Status:	
Address:		City:		State:	Zip:
Home Phone:			Work Phone:		
Referring Physician:			Family Physician:		
WERE YOU INJURED ON THE JOB? IF SO					
Industrial Claim #		Date of Incident:		Insurance Carrier:	
Employer:				Work Phone:	
Work Address:		City:		State:	Zip:
INSURANCE INFORMATION					
PRIMARY Ins. Co. Name:		Date of Incident:		Insurance Carrier:	
Group Name or No:			Insurance I.D. No.:		
Billing Address:				Phone:	
Insured Name:		DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
Secondary Ins. Co. Name:					
Group Name or No:			Insurance I.D. No.:		
Billing Address:				Phone:	
Insured Name:		DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE					
Name:			Home Phone:		Work Phone:
Street Address:	Apt. No.:		City:		State:
DOB:	SS#			Drivers License No.:	
Relationship to Patient: (Wife, Husband, Mother, Father, Guardian, Other)					

AUTHORIZATION: I hereby authorize Northern Arizona Radiology, physicians to furnish information to insurance carriers concerning this illness / accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature

Date