



Patient Information

Name _____ Sex _____ Birthdate _____

Phone (H) _____ Work Phone _____

SSN _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Emergency Contact Person (Not living with you)

Name _____ Phone (H) _____ Phone (Alt) _____

Responsible Party Information

Name _____ Address _____

Relationship _____ SSN _____ Birthdate _____

Employer _____ Phone _____

Insurance

On the job injury? _____ Motor Vehicle Accident? _____

PRIMARY INSURANCE

SECONDARY INSURANCE

TERTIARY INSURANCE

Carrier _____

Address _____

City State Zip _____

Policy Holder _____

Pol Holder SSN _____

Pol Holder DOB _____

Policy Number _____

Group Number _____

Authorization _____

Adjuster _____

Release of Information and Payment Authorization

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to university Imaging. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize University Imaging to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges.

I understand that University Imaging is not responsible for valuables and personal property brought in to the facility. Initials: _____

I acknowledge that I have received a copy of University Imaging's Privacy Notice. Initials: _____

Patient or Guardian Name _____ Signature _____ Date _____

