ASHEVILLE RADIOLOGY

Patient ID Label

In order to help us quickly process this form, we ask your assistance in providing us with complete printed information. If you have insurance, please show us your card so we may copy it.

PARENT/GUARDIAN (If patient is under 18)

First Name ____________ Last Name ____________ MI ______

Social Security # ____________ Date of Birth___/___/___ Home Phone ____________

Mailing Address ____________ City/State/Zip ____________

PATIENT

First Name ____________ Last Name ____________ MI ______ ❑ Male ❑ Female

Social Security # ____________ Date of Birth___/___/___ Home Phone ____________

Street Address ____________ Mailing Address ____________

City/State/Zip ____________ City/State/Zip ____________

Residence is a skilled nursing facility, Facility Name : ____________

Employment Status: ❑ Employed ❑ Self-employed ❑ Retired ❑ Disabled ❑ Homemaker ❑ Student ❑ Minor

Employer ____________ Employer Phone ____________

Employer's Address ____________ City/State/Zip ____________

PLEASE COMPLETE THOSE ITEMS BELOW THAT APPLY TO YOU:

INSURANCE (Primary)

Name of Insurance ____________

Address ____________

City ____________ State ______

Phone ____________ Zip ______

Group # ____________ Policy # ____________

Policyholder's relationship to patient:

❑ Self ❑ Parent ❑ Spouse ❑ Other

POLICYHOLDER INFORMATION (If other than Patient)

Name ____________

Social Security # ____________ DOB ______

Employer ____________

Phone ____________

INSURANCE (secondary)

Name of Insurance ____________

Address ____________

City ____________ State ______

Phone ____________ Zip ______

Group # ____________ Policy # ____________

Policyholders Relationship to Patient:

❑ Self ❑ Parent ❑ Spouse ❑ Other

POLICYHOLDER INFORMATION (If other than Patient)

Name ____________

Social Security # ____________ DOB ______

Employer ____________

Phone ____________

WORKERS COMPENSATION INSURANCE

Name of Insurance ____________

Claim Address ____________

Claim Number ____________

City ____________ State ______ Zip ______

Is today's exam related to workers compensation? Yes No

Has the injury been reported to the employer? Yes No

WORKERS COMPENSATION CLAIM

Date of Injury ____________

Nature of Injury ____________

Contact Person ____________

Contact Phone ____________

If Yes, Inform Receptionist for additional information

PATIENT SIGNATURE ____________ **DATE** ____________