CEDAR LAKE MRI

PATIENT INFORMATION SHEET

Date: _____ Sex: M___ F___ SS# _____

Patient Name: _____ Birthday: ___/___/___ Age: ____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____

Marital Status: Single___ Married___ Divorced___ Widowed___ Separated___ Email: _____

Guarantor Name: _____ Birthday: ___/___/___ Age: ____
Last First MI

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: _____ Alternate Phone: _____ SS#_____

Preferred Pharmacy name: _____ Preferred Pharmacy Location:_____

Group Physician: _____ Primary Care Physician: _____

Referring physician: _____ Referring Physician Location: _____

Employers Name: _____ Work Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Cell Phone: _____

Insurance Information: (Please submit insurance cards for photocopy)

Primary:
Name of Company _____
Address _____
Policy# _____ Effective Date ___/___/___
Insured's Name _____ SS# _____
Date of Birth ___/___/___ Relationship to patient _____
Employer's Name _____

Secondary:
Name of Company _____
Address _____
Policy# _____ Effective Date ___/___/___
Insured's Name _____ SS# _____
Date of Birth ___/___/___ Relationship to patient _____
Employer's Name _____

I hereby assign, transfer and set over to Cedar Lake MRI all of my rights, title and interest to medical reimbursement benefits under my insurance policy.

Sign: _____ Date: ___/___/___