

Central Imaging Open MRI, Inc.
PATIENT INFORMATION/VERIFICATION

TODAY'S DATE: _____

PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: _____ MARRIED _____ SINGLE _____ DIVORCED _____ WIDOW(ER) _____

DATE OF BIRTH: _____ SSN #: _____ MALE: _____ FEMALE: _____

EMPLOYER: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ DOB: _____ RELATIONSHIP TO INSURED _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP PLAN #: _____

SECONDARY INSURANCE: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP PLAN #: _____

ATTORNEY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

REFERRING PHYSICIAN: _____ TELEPHONE: _____

DO YOU HAVE A FOLLOW UP APPOINTMENT? YES _____ NO _____ IF YES, WHEN? _____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE: _____

WOULD YOU LIKE US TO SEND THIS MRI REPORT TO ANY DOCTOR NOT LISTED? _____

IS YOUR CONDITION RELATED TO:

EMPLOYMENT? YES _____ NO _____ INJURY DATE: _____ CLAIM #: _____

ACCIDENT? YES _____ NO _____ INJURY DATE: _____ CLAIM #: _____

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ALL THAT APPLY) _____ TELEVISION _____ RADIO
_____ MAGAZINE _____ FRIEND _____ PHYSICIAN _____ BEEN HERE BEFORE
_____ NEWSPAPER (which one) _____ OTHER (please explain) _____