



PATIENT INFORMATION FORM

Today's Date _____ Appt. Date _____ New patient? Y N

Referring Physician _____ Primary Care Physician _____

Patient Personal Information: _____

Name _____ Date of Birth _____

SSN _____

Mailing address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name _____ Address _____

Occupation _____ Phone Number _____

Billing information: _____

_____ Copy of insurance card attached (if card not available use separate form)

Primary Insurance Co. _____

Subscriber name and employer (if different from above): _____

Subscriber Name _____ Patient Relationship to Subscriber _____

Subscriber Employer Name _____

Secondary Insurance Co. _____ Subscriber name _____

If minor, name of patient/guardian: _____ phone _____

Relationship _____ address (if different) _____

Emergency Contact: _____

Name _____ Phone _____

Assignment and Release:

I authorize treatment and the release of any medical or other necessary information to process claims to my insurance company. I authorize and assign direct payment from my insurance company to Breast Imaging of Savannah LLC. I understand the charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility. I fully understand that should I decide, at any time, to file my own claims, I am financially responsible in full at time of service for any debt I incur with Breast Imaging of Savannah LLC.

We will file non-contracted insurance as a courtesy; however, if we have no response from your insurance company within 60 days, the charges will be transferred to your responsibility to pay.

Patient Signature: _____ Date: _____