ISLAND IMAGING

*PLEASE PRINT CLEARLY*

SOCIAL SECURITY # _____ BIRTHDATE: ____/____/____ SEX: ❒ FEMALE ❒ MALE

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ APT: _____

CITY/STATE/ZIP: _____ COUNTRY: _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

EMPLOYMENT: ❒ FULL TIME ❒ PART TIME ❒ NOT EMP ❒ SELF EMP ❒ RETIRED ❒ MILITARY

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMAIL: _____ STUDENT: ❒ YES ❒ NO

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOWED ❒ SEPARATED

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

INSURANCE: _____ POLICY # _____

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***IF THE PATIENT IS A MINOR OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:***

LEGAL GUARDIAN/RESPONSIBLE PARTY: _____

RELATION TO PATIENT: _____

ADDRESS: _____ SS# _____

PHONE# _____

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***EMERGENCY CONTACT: PLEASE LIST SOMEONE YOU WOULD LIKE US TO CONTACT IN THE EVENT OF AN EMERGENCY.***

NAME: _____ ADDRESS: _____

HOME PHONE # _____ EMPLOYER: _____

WORK PHONE# _____ ADDITIONAL INFO: _____

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***ASSIGNMENT AND RELEASE:*** Authorization to treat and release information to insurance carrier for direct payment to the provider. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize any holder of medical or other information about me to release to my insurance company or the Social Security Administration any information needed for this or any related claim. I permit and request payment of medical benefits either to myself or to the party who accepts assignment. Regulations pertaining to the assignment of benefits apply. I understand that I am obligated to pay any charges deemed medically unnecessary of classified non-covered charges by Medicare.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

***IF PATIENT IS A MINOR OR UNABLE TO SIGN HIS OR HER NAME:***

LEGAL GUARDIAN: _____ SIGNATURE: _____ DATE: _____