

1960 Digital Imaging  
PATIENT PROFILE

Office Use :

Revd by : \_\_\_\_\_

Entrd by : \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_ Sex: [ ]M [ ]F

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Marital Status: [ ] Married [ ] Single

Work Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**PATIENT EMPLOYMENT**

[ ] Employed [ ] Retired [ ] Not Employed

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

**EMERGENCY CONTACTS ( NAME & PHONE)**

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

**RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)**

[ ] Same as Patient [ ] Same as Insured

Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security#: \_\_\_\_\_

**PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your insurance.)**

Name of Insured: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insured SS#: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

Policy Group #: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

**\*\*\*\* IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES / NO**  
**(IF YES, PLEASE COMPLETE SECONDARY INSURANCE BELOW.)**

**SECONDARY INSURANCE (if applicable)**

Name of Insured: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insured SS#: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

Policy Group #: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

How did you hear about us?: \_\_\_ family/friend \_\_\_ doctor \_\_\_ location \_\_\_ yellow pages \_\_\_ insurance \_\_\_ internet \_\_\_ other:

Patient/Responsibility Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_