SOUTHWEST DIAGNOSTIC CENTERS - PATIENT INFORMATION

Patient Name ____ **DOB** __________________ **Age** _______

MALE FEMALE (please circle) Social Security Number _________________________ **Marital Status** ______

Address _____________________________________ **City** ________________ **State** ________ **ZIP** _________

Home Phone (____) _____________ **Cell Phone (____)** _______________ **Work Phone (_____)** _______________

Employer ____________________________ **Referring Physician** ______________________________________

GUARANTOR INFORMATION (person who holds the insurance policy)

Name ____ **Relationship to Patient** ________________

DOB _____________ **Social Security Number** ____________________ **Employer** _________________________

Address ___________________________________ **City** ____________________ **State** _____ **Zip** __________

Home Phone (_______) ___________________ **Cell or Work Phone (_______)**_____________________________

EMERGENCY CONTACT (not living at home)

Name ____ **Relationship to Patient** _________________

Address __________________________________ **City** ____________________ **State** _____ **Zip** ___________

Home Phone (_______) ___________________ **Cell or work phone (_______)** _____________________________

INSURANCE INFORMATION

Name of Insurance Company we are billing: ____

City ____ **State** ________________ **Zip** _________________

Phone Number (______) __________________________

Policy or Claim Number ___________________________ **Group Number** ________________________________

ACCIDENT INFORMATION (only fill out if you were involved in an accident)

Date of Injury _____/______/______ Type of Accident (please circle) **AUTO WORK COMP OTHER HOME**

Claims Adjustor Name ____________________________________ **Phone Number (_____)** __________________

ATTORNEY INFORMATION (only fill out if you are being represented by an attorney)

Name ____ **Phone Number (______)** _____________________

City ____ **State** ________ **Zip** _______________

I AGREE THAT THE INFORMATION I HAVE PROVIDED ABOVE TO SOUTHWEST DIAGNOSTIC CENTERS IS ACCURATE AND TRUE.

____ ____________________________

Signature of Patient or Responsible Party **Date**

I authorize Southwest Diagnostic Centers to release to my insurance company any medical information which may be necessary for processing my insurance claim. I authorize my insurance company to pay any benefits directly to Southwest Diagnostic Centers.

____ **Date** ______________________

Signature of Patient, or personal representative

Relationship to patient ________________________________