SMI ID# ____________
(FOR OFFICE USE)

PATIENT DEMOGRAPHICS

PATIENT NAME: ______________________ DATE OF BIRTH: ________ GENDER: M or F

HOME ADDRESS: ______________________ CITY/STATE/ZIP: ______________________

HOME PHONE: WORK PHONE: ____________ CELL PHONE: ______________

SOCIAL SECURITY #: ______________ MARITAL STATUS: M D S STUDENT: YES NO

EMPLOYER: ____ ADDRESS: ______________________

EMERGENCY CONTACT: ______________ PHONE: ______________ RELATION: ______________

REFERRING PHYSICIAN: ______________ PRIMARY CARE PHYSICIAN: ______________

PRIMARY INSURANCE

INSURANCE NAME: ______________ PHONE #: ______________ NETWORK: ______

ADDRESS: ____

POLICYHOLDER: NAME ______________ SOC. SEC. # ______________ DOB ______________

POLICY HOLDER ID#: ______________________ GROUP #: ______________

RELATIONSHIP TO PT: ______________ POLICY HOLDER EMPLOYER: ______________

AUTHORIZATION NUMBER: ______________

SECONDARY INSURANCE

INSURANCE NAME: ______________ PHONE #: ______________ NETWORK: ______

ADDRESS: ____

POLICYHOLDER: NAME ______________ SOC. SEC. # ______________ DOB ______________

POLICY HOLDER ID#: ______________________ GROUP #: ______________

RELATIONSHIP TO PT: ______________ POLICY HOLDER EMPLOYER: ______________

AUTHORIZATION NUMBER: ______________

IF THIS IS AN ACCIDENT OR WORK RELATED INJURY, PLEASE EXPLAIN: ______________________
____

CLAIM #: ______________ CONTACT PERSON: ______________ PHONE #: ______________

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE STONEBRIAR MEDICAL IMAGING OR WARREN MEDICAL IMAGING TO RELEASE AND/OR OBTAIN ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I ALSO AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO STONEBRIAR MEDICAL IMAGING OR WARREN MEDICAL IMAGING. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND ANY BALANCES REMAINING AFTER INSURANCE PAYS.

NOTICE OF PRIVACY PRACTICE: I have been offered a copy of the Notice of Privacy from SMI AND WMI concerning how the use or disclosure of protected health information will be handled by the practice.

SIGNATURE: ______________________________ DATE: ______________