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: ____

POLICY HOLDER*:* NAME ______________________ SOC. SEC. # __________________ DOB __________________

POLICY HOLDER ID#: ____ GROUP #: ___________________________

RELATIONSHIP TO PT: ________________ POLICY HOLDER EMPLOYER: _______________________________

AUTHORIZATION NUMBER: _______________________

SECONDARY INSURANCE

INSURANCE NAME: ______________________________ PHONE #: ____________________ NETWORK: ______

ADDRESS: ____

POLICY HOLDER*:* 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: _________________________