



- NC Baptist M&S Imaging
- Baptist M&S Imaging and PET
- Baptist M&S NE MRI/CT
- Baptist M&S SE Imaging

- Baptist M&S Imaging Westover Hills
- Baptist M&S Imaging Downtown
- Baptist M&S Imaging Oakwell Farms

PATIENT INFORMATION

Last Name:		First Name:		Middle Initial:
Street Address:	City:	State:		Zip Code:
Home Phone #:	Social Security #:	Date of Birth: Mo./Day/Year		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Name of Employer	Business Phone:	Date of Injury: Mo./Day/Year		Claim #
Street Address:	City:	State:		Zip Code:

RESPONSIBLE PARTY

The Responsible Party is the person, company or organization ultimately responsible for payment of services. If the Patient and the Guarantor are the same, write "See Patient" in the box for Last Name.

Last Name:		First Name:		Middle Initial:	Relationship to Patient:
Street Address:	City:	State:		Zip Code:	
Home Phone #:	Social Security #:	Date of Birth: Mo./Day/Year		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

PRIMARY INSURANCE

The Policyholder is the person whose name is on the insurance policy. This may be the Patient, the Responsible Party or a different person. If the Policyholder is the same as the Patient, write "SEE PATIENT" in the box for Last Name, but please do not forget to fill in the Insurance Information. If the Patient does not have insurance coverage, write "NONE" in the box for Insurance Carrier.

Insurance Carrier:	Insurance Phone #:	Policy #	Plan:	Group #:
Policy Holder Last Name:	First Name:		Middle Initial:	Relationship to Patient:
Street Address:	City:	State:		Zip Code:
Home Phone #:	Social Security #:	Date of Birth: Mo./Day/Year		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Name of Employer:				Business Phone #:
Street Address:	City:	State:		Zip Code:

SECONDARY INSURANCE

Insurance Carrier:	Insurance Phone #:	Policy #:	Plan:	Group #:
Policy Holder Last Name:	First Name:		Middle Initial:	Relationship to Patient:
Street Address:	City:	State:		Zip Code:
Home Phone #:	Social Security #:	Date of Birth: Mo./Day/Year		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Name of Employer:				Business Phone #:
Street Address:	City:	State:		Zip Code: