Print

PATIENT INFORMATION SHEET

PLEASE PRINT

Patient Name: _____ _____ _____ _____
First Middle Initial Last Suffix

Date of Birth: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____ _____
Please enter address where you receive your mail Apt./Lot/Unit #

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate phone: _____ Cell phone: _____

May we leave confidential messages at any of these numbers? ☐ Yes ☐ No

Email Address: _____

Emergency contact name: _____ Phone #: _____

GUARANTOR / PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____

Relationship to patient: _____

Phone: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

PATIENT EMPLOYER INFORMATION (Worker's Comp cases)

Employer Name: _____

Business Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Date of Injury: _____

Claim #: _____

INSURANCE POLICY HOLDER INFORMATION

PRIMARY Policy Holder Name: _____ Patient relationship: _____

Address *(include city, state, zip)*: _____

DOB: _____ Gender: _____

SECONDARY Policy Holder Name: _____ Patient relationship: _____

Address *(include city, state, zip)*: _____

DOB: _____ Gender: _____

Are you currently receiving Skilled Nursing or Hospice Care? ☐ Yes ☐ No Provide name of nursing facility: _____

RELEASE/AUTHORIZATION OF MEDICAL INFORMATION

All information in our office is kept confidential. Please list names of anyone whom you authorize our office to discuss your medical condition, treatment, radiology results, appointments, billing, insurance benefits and/or to obtain copies of films, CD's or reports. ***If you want your information to remain confidential please write "NONE".*** *Baptist M&S Imaging may request healthcare information from other healthcare providers for continuation of my care. (Films, CD's, Pathology results and reports related to Imaging). Baptist M&S Imaging may also share my health information with medical providers, other than my referring provider, for healthcare needs.*

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

It is your responsibility to notify our office if this information changes.

Patient/Guardian Printed Name **Patient/Guardian Signature** **Date**

_____ _____ _____

Reset Form