



(please print)

NEW PATIENT INFORMATION

Patient Name: _____ Date: _____
 Last (Include Jr, Sr, MD etc) First MI

Previous Name(s) and/or Also Known As Name(s) _____

Phones : (_____) _____ (_____) _____ (_____) _____
 Home Cell Work

Mailing Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age _____ Male Female SS#: _____ - _____ - _____

Check One: Employed Retired Disabled Unemployed Employer: _____

Ordering Physician: _____ Add'l Copy to Dr. _____

RESPONSIBLE PARTY IF DIFFERENT THAN ABOVE

Name: _____ Relationship To Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age _____ Male Female SS#: _____ - _____ - _____

Check One: Employed Retired Disabled Unemployed Employer: _____
 Company Work Phone Number

INSURANCE INFORMATION

Check What Applies: Illness On The Job MVA Other Date of Injury: _____ / _____ / _____

If On The Job Injury - Employer on Injury Date or Employer Insurance is through: _____

Primary Ins. Co.: _____ Secondary Ins. Co.: _____

Insured's Name: _____ Insured's Name: _____

DOB: _____ SS # _____ / _____ / _____ DOB: _____ SS # _____ / _____ / _____

Group# _____ ID # _____ Group# _____ ID # _____

AUTHORIZATION AND FINANCIAL AGREEMENT FOR DIAGNOSTIC RADIOLOGY SERVICES

I authorize treatment of the person named above and agree to pay all fees and charges. I understand I am financially responsible to CORA/COMRI/CMI for all charges for services regardless of insurance coverage. It is agreed that payments will not be delayed or withheld because of any insurance or the pendency of claims thereon. I agree to pay all charges for myself and my family shown by my statements. In the event legal action is necessary to collect an unpaid balance due for services rendered to myself or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines.

I hereby authorize CORA/COMRI/CMI to release any necessary medical information for my care and treatment.

X Signature of Patient or Guarantor: _____ Date: _____

