PATIENT INFORMATION SHEET

PLEASE PRINT

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

Date of Birth: _____________ Gender: ☐ Male ☐ Female Social Security #: ________________________

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: ________________________________ May we send you a brief satisfaction survey? ☐ Yes ☐ No

Emergency contact name: __________________________ Phone #: ____________________________

GUARANTOR / PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: ____

Relationship to patient: _____________________________

Phone: __________________________ DOB: ___________

Social Security #: ___________________________________

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)*: ____

Social Security #: ______________________________________ DOB: ______________________________ Gender: _____________

SECONDARY Policy Holder Name: ____ Patient relationship: ________________________

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

Social Security #: ______________________________________ 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**

___________________________ ________________________________ ______________________