PATIENT INFORMATION FORM

PATIENT INFORMATION

Date:		**Primary Provider:**			
Patient's name Last:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #:	Birth date:	Age:	Sex: ❑ M ❑ F
Address:		Home Phone#: ( )		Cell Phone#: ( )	
P.O. Box:	City:	State:		ZIP Code:	
Occupation:	Employer:			Employer phone #: ( )	
Who referred you or how did you find us? (please check one box):	❑ Dr.	❑ Billings Gazette	❑ LaVie		
❑ Family	❑ Friend	❑ Internet	❑ Radio	❑ Other	
Other family members seen here:					

GUARANTOR INFORMATION

Guarantor Name:	Birth date:	Address (if different):	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
Occupation:	Employer:		
Relationship to Patient: ❑ Parent ❑ Spouse ❑ Other			

INSURANCE INFORMATION

Name of primary insurance:				
Subscriber's name:	Subscriber's S.S. #:	Birth date:	Policy #:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):				
Subscriber's name:	Subscriber's S.S. #:	Birth date:	Policy #:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

My signature below acknowledges that I voluntarily give my authorization and consent to the performance of the ultrasound procedure(s) referred by my provider to *Picture Perfect Ultrasound*. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Picture Perfect Ultrasound or Buffy Stiles RT RDMS RVT (Ultrasound Provider). I understand that I am financially responsible for any balance remaining after insurance and that I have 90 days from the date of service to have my balance paid in full unless other payment arrangements have been made. **I understand that in the event my outstanding account is assigned to a collection's agency, I will pay an additional collections fee of 25% of the unpaid balance due.** I also authorize Picture Perfect Ultrasound or my insurance company to release any information required to process my claims. Picture Perfect Ultrasound will contact me regarding any remaining balances due.

PATIENT/GUARDIAN Signature: **Date:**