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

EMAIL ADDRESS:

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 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:**