Patient Information Sheet

Name:____ Date of Birth:____________

Social Security # __________________ Height______Weight______ Marital Status: ___

Mailing Address:____
Street Address

____
City State Zip Code

Phone #________________ Work #__________________ Cell#___________________

Employer ______________________ Occupation:_________________ Sex: M___ F___

Do you have a pacemaker? ____yes ______no

INSURED (PERSON RESPONSIBLE) INFORMATION (if other than patient)

Name:______________________________Relationship to Patient:___________________

Address(if different)____

Social Security #________________________________ Date of Birth________________

Home #______________Work #______________Employer________________________

I hereby authorize Imaging Center of Columbus, to perform the test ordered by my physician and to release information requested by my insurance company or worker's compensation carrier which may be necessary to process my claim for payment. I authorize the release of any medical information necessary for treatment by my current or future physicians or healthcare providers I may be referred to. I understand I am ultimately responsible for payment of any and all charges and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full. I hereby authorize payment of Medical Benefits to Imaging Center of Columbus. I agree that a photocopy of this form may be used in lieu of the original.

If you have any questions, feel free to ask the technologist performing your exam. We would like for your exam to be as pleasant as possible. We want to thank you for choosing Imaging Center of Columbus for your test today.

PATIENT'S NAME (PRINT):____

SIGNATURE OF PATIENT:_____________________________________**DATE:**__________

WITNESS:____**DATE:**__________

NOTE: Any disclosure of medical record information by the recipient is prohibited except when implicit in the purpose of disclosure.