IMAGING AT ELIZABETH PLACE
One Elizabeth Place - Dayton, Ohio 45408
Phone (937) 660-8774 Fax (888) 813-0121

PATIENT INFORMATION

FIRST: _____ MI: _____ LAST:_____

BIRTH DATE: _____/_____/_____ S.S. #_____/_____/_____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

HOME PHONE: {___} _____ CELL: {___} _____

EMPLOYER: _____ WORK #: {___} _____

WORK ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

MARITAL STATUS: M S D W SPOUSE'S NAME: _____

FAMILY PHYSICIAN: _____ORDERING PHYSICIAN: _____

EMERGENCY CONTACT

EMERGENCY CONTACT: _____

PHONE: {___} _____ RELATIONSHIP: _____

RESPONSIBLE PARTY

FIRST: _____ MI: _____ LAST:_____

BIRTH DATE: _____/_____/_____ S.S. # _____/_____/_____

PHONE: {___} _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

POLICY HOLDER'S NAME: _____

BIRTH DATE: _____/_____/_____ S.S. # _____/_____/_____

PHONE: {___} _____ RELATIONSHIP: _____

ID #: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICY HOLDER'S NAME: _____

BIRTH DATE: _____/_____/_____ S.S. # _____/_____/_____

PHONE: {___} _____ RELATIONSHIP: _____

ID #: _____ GROUP #: _____

PATIENT SIGNATURE:

_____ DATE: _____

PARENT/GUARDIAN SIGNATURE {if patient is a minor}

_____ DATE: _____

Patient has received "Notice of Privacy Practices" and "Patient Rights"

PATIENTS INITIALS: _____