



AMERICAN RADIOLOGY SERVICES

New Patient Information

Last Name:	Social Security #:
First Name:	Date of Birth:
Middle-Name:	Sex:

Patient Home Address	Home Phone:
Street:	
City:	Work Phone:
State:	Zip Code:
Email Address: _____	

Verified photo ID Yes No If no, verified other ID Yes No Initials

Referring Doctor(s): 1
2

Individual Responsible for the Bill/Guarantor:
Billing Address (if other than given above):
Guarantor Phone Number (if other than given above):

Primary Insurance

Insurance Company Name:	
Subscriber ID #:	Group #:
Insurance Holder's Name:	
Insurance Holder's Date of Birth:	
Insurance Holder's Sex:	
Insurance Holder's Employer:	
Insurance Holder's Relationship to Patient:	

Secondary Insurance

Insurance Company Name:	
Subscriber ID #:	Group #:
Insurance Holder's Name:	
Insurance Holder's Date of Birth:	
Insurance Holder's Sex:	
Insurance Holder's Employer:	
Insurance Holder's Relationship to Patient:	

Alternate ID's (internal use): Last Visit Date:

CONSENT FOR TREATMENT: I consent to the diagnostic procedures, tests and treatment deemed necessary by my doctor and American Radiology Services, Inc. No guarantees have been made to me about the outcome of procedures, tests and treatment rendered to me by American Radiology Services, Inc.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I authorize American Radiology Services, Inc. to furnish information to any Insurance Carrier concerning my illness and treatments and assign the payments for medical services to American Radiology Services, Inc. I understand I am responsible for any amount not covered by insurance. I understand I am also responsible for any collection fees owed by me to American Radiology Services, Inc.

Signature:	Date:
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RECEIPT OF NOTICE OF PRIVACY PRACTICES: I certify that I have received, at this visit or a previous visit, a copy of American Radiology Services, Inc. and American Radiology Associates, P.A. Notice of Privacy Practices	
Signature:	Date: