

TODAY'S DATE: _____
PATIENT NAME: _____ BIRTHDATE: _____ SEX: _____
PATIENTS MAILING ADDRESS: _____ SS #: _____
CITY _____ STATE: _____ ZIP CODE _____
TELEPHONE #: _____ OTHER PHONE: _____

PRIMARY INSURANCE HOLDERS INFO: IF PATIENT CHECK HERE _____
GUARANTOR NAME: _____ GUARANTOR BIRTH DATE: _____
GUARANTOR PHONE #: _____ GUARANTOR SS #: _____
GUARANTOR MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE _____
EMPLOYER: _____ EMPLOYER PHONE NO. _____
EMPLOYER ADDRESS: _____ CITY/STATE: _____ ZIP _____

SECOND INSURANCE HOLDERS INFO: IF PATIENT CHECK HERE _____ NONE _____
SECOND INS. HOLDER NAME: _____ DATE OF BIRTH _____
TELEPHONE: _____ SS # _____
MAILING ADDRESS: _____
CITY _____ STATE: _____ ZIP CODE _____

IS THIS VISIT A RESULT OF AN AUTO ACCIDENT? _____ YES _____ NO
IS THIS VISIT COVERED BY WORKERS COMPENSATION? _____ YES _____ NO
IF "YES": CLAIM # _____ DATE OF INCIDENT _____

IF THE ANSWER TO EITHER OF THESE QUESTIONS IS "YES" PLEASE BE SURE WE HAVE ALL NECESSARY INFORMATION. THANK YOU.

I, the undersigned certify the I (or my dependent) have insurance with _____ (ins. co.) and assign payment directly to Advanced Imaging Associates. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PATIENT/GUARDIAN SIGNATURE TODAY'S DATE

WHY DID YOU CHOOSE AIA: _____ PHYSICIAN _____ CONVENIENCE TO WORK/HOME
_____ FAMILY/RELATIVE _____ PHONE LISTING _____ ADVERTISEMENT _____