HOMER GLEN IMAGING

Patient Information Sheet

Last Name: _____ First Name: _____

Birthdate: _____-_____-_____Age:_____

Social Security #:_____-_____-_____

Street Address: _____Apt/Unit#:_____

City: _____State:_____ Zip Code:_____

Home Phone #:_____-_____-_____Cellular Phone #:_____-_____-_____

Emergency Contact

Last Name: _____ First Name: _____

Home Phone #:_____-_____-_____Cellular Phone #:_____-_____-_____

Relationship: _____

Primary Insurance

(Please provide office with copy)

If card holder is other than yourself, please provide the card holder information below:

Card Holder's Name: _____

Social Security #:_____-_____-_____Birthdate:_____-_____-_____

Refering Physician: _____

Assignment and Release

I, the undersigned certify (or my dependent) have insurance coverage with _____ and assign directly to **Homer Glen Open MRI & Imaging** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize **Homer Glen Open MRI & Imaging** release all insurance necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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