Patient Information Record

Account Number : _____ Date : _____

Patient Name : _____

Address : _____

City, State, Zip : _____

Home Phone Number : _____

Cell Phone Number : _____

Email Address :_____

Preferred method of contact: _____ Home _____Cell _____Email _____Text

Date of Birth : _____

Social Security Number: _____ - _____ - _____

Allergy Information: __ IODINE __ LATEX

Parent/Guardian/Responsible Party *(Only if patient is a minor)

Name _____ D.O.B ___/___/___ Relation/SSN _____

Employers Name Employers Address Phone #

_____

Emergency Contact Required

Name:_____ Phone Number:_____

Relationship:_____

Primary Insurance:

Insurance: ID#: Group#:
Insured:

Secondary Insurance:

Insurance: ID#: Group#:
Insured:

Is this visit related to an Auto Accident or a Work Injury? ___ Yes ___ No If yes, date of injury? ___/___/____

What physicians do you want to receive a copy of today's report? _____

_____ _____
Signature Date

Diagnostic Imaging Acknowledgement

Patient Name: _____ Referring Physician:_____ Exam/Procedure: _____

Due to the complex requirements of most third party payors, including Medicare and Medicaid, as a Diagnostic Company we must obtain your previous history regarding any similar diagnostic procedure within the last year. Please check the following box that applies to you.

I have had this same diagnostic procedure within the past (1) year.

___ **YES**, If you have had this same study in the time period mentioned, we will need to contact your insurance company for special authorization. Without that approval, we will not be able to provide this study unless you are willing to pay the procedure in advance.

___ **NO**, I have not had this same diagnostic procedure within the past (1) year. If you are unsure, we will contact your insurance company to verify; however, this may cause a delay in providing your procedure.

By checking NO, we are able to perform this study without delay. If it is later determined that you have had this study within the past year, and the third party payor refuses payment, then you will be responsible for the entire balance not to exceed Medicare allowable.

Signature _____ Date _____

Consent to Perform Exam

I hereby give consent to Emery Medical Solutions to provide the testing that the assigned physician may deem necessary to the patient named above.

Signature _____ Date _____

Medical Release

This section of the encounter form authorizes all physicians, hospitals and medical attendants to furnish to:
Full and complete medical reports, films and other information that are requested by this facility, affording them to examine a copy of medical records to obtain evaluations and options concerning prior subsequent medical care. The patient has the right to revoke this authorization at any time. This authorization will expire 1 year from the date of completion.

Signature _____ Date _____

Assignment of Benefits

Signature of this document authorizes medical benefits to Emery Medical Solutions, Inc for services rendered, release of results to physicians, release of medical information to insure (including Medicare, its agents, and third party payers) necessary to process and request payment for services rendered, and acceptance of responsibility for payment of said charges if Emery Medical Solutions, Inc is denied payment from insurance or providers for services rendered. I hereby designate assignment and release to **Emery Medical Solutions, Inc at 2151 E. Semoran Blvd, Apopka, Fl. 32703, Phone (407) 628-9100 Fax (407) 628-0748**.

Signature _____ Date _____