WEINSTEIN IMAGING ASSOCIATES

PATIENT INFORMATION

Your Referring Physician Name:		Office Address:		Office Phone Number:
Your Primary Care Physician (PCP) Name:		Office Address:		Office Phone Number:
Patient Last Name:	First:	Middle:	Date of Birth:	Age:
Address: Street Name/No.:		City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Social Security Number:	
Patient's Occupation:		Company Name:		
Spouse or Guardian's Name:	Spouse or Guardian's Date of Birth:	Spouse or Guardian's Address (if different from patient's):		
Spouse's Occupation:		Company Name/Telephone Number:		
Primary Insurance Plan:	Insurance Company Address: (if Highmark or Medicare, do not fill in address or phone)		Insurance Company Phone Number:	
Policyholder (self,spouse,etc):	Group or Policy Number:		ID or Agreement Number:	
Secondary Insurance Plan:	Insurance Company Address: (if Highmark or Medicare, do not fill in address or phone)		Insurance Company Phone Number:	
Policyholder (self,spouse,etc):	Group or Policy Number:		ID or Agreement Number:	

RELEASE AND ASSIGNMENT

I hereby consent to any necessary medical diagnosis and treatment for myself, child, or the above named minor for whom I am legally responsible. The release of medical information to any insurance carrier, and direct payment to this practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of the charges for medical services rendered.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (if patient is a minor) Date