UP&OPEN IMAGING
UPRIGHT MRI

PATIENT INFORMATION SHEET

Patient Name: _____
Last Name First Name Middle Name

Date of Birth: ___/___/___ **Social Security Number:** _____ - ____ - _____ **Sex:** _____

Marital Status: _____

Home Address: _____
Street Apartment #

_____
City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Work Phone: _____

**Please indicate by circling which phone numbers (if any) are acceptable for our office staff to leave a message with regards to your procedure.*

In the case of an emergency, please contact: _____ **Phone Number:** _____

Referring Physician: _____

When is your follow-up appointment with your referring doctor? _____

Insurance Company: _____ **Name of Insured:** _____

Insured ID: _____ **Policy Group #** _____

Date of Birth: ___/___/___ **Social Security Number:** _____ - ____ - _____

If this is a Worker's Compensation claim, please indicate the following:

Accident Date: _____ **Employer:** _____

Claim Number: _____ **Employer Phone:** _____

Please read prior to signing

I understand that this office files my insurance, as a courtesy, and that payment of these services are ultimately my responsibility. Any monies due with regards to today's visit are an estimate and are subject to change depending upon the insurance plan's specific reimbursement policies. I permit the insurance company to make payment directly to Up & Open Imaging any benefits due. This does not apply to Texas Worker's Compensation Claims.

I authorize this facility to release and / or obtain any information, which were acquired in the course of my examination or treatment to referring doctors and or insurance companies.

_____ _____
Signature of Patient, Parent or Legal Guardian Date