smartscan MEDICAL IMAGING LLC

Office Use Only

Date:
MRN:
ID Verified:

Patient Information

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Address: _____City: _____State: _____ Zip: _____

Gender: _____ Marital Status: _____ Referring Physician: _____

Phone: ☐ Cell ☐ Home _____ Email: _____

(I understand if information is emailed, there may be some level of risk that the information could be viewed by an unauthorized party and I accept these risks. By providing my contact information I authorize SSMI, its physicians and staff to communicate with me electronically about my care, account and services.)

PCP: _____

List Allergies: _____

List Medications:_____

Employer (For Workman's Comp)

Employer Name: _____ Claim#: _____ ☐ Retired

Employer Phone: _____ Occupation: _____

Phone: ☐ Cell ☐ Home _____ Email: _____

Address: _____City: _____State: _____ Zip: _____

Is your Injury due to: ☐ Work Accident ☐ Auto Accident ☐ 3rd Party Liability

Health Insurance Coverage:

Primary

Insurance Co Name:_____

Insurance Phone: _____

Policy Holder Name: _____

Policy #: _____

Policy Holder DOB: _____

Relationship to Patient: _____

Insured's Employer: _____

Employer Phone: _____

Secondary

Insurance Co Name:_____

Insurance Phone: _____

Policy Holder Name: _____

Policy #:_____

Policy Holder DOB: _____

Relationship to Patient: _____

Insured's Employer: _____

Employer Phone: _____

I acknowledge the information provided above is true and accurate:

Name of person completing this form: _____ Relationship: _____

Signature of person completing this form: _____Date: _____