

PATIENT REGISTRATION

Name			Social Security #		-	-
<i>Last</i>	<i>First</i>	<i>Middle</i>				
Address		Birth Date:	Cell phone ()		Age	
City	St	Zip	Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Date of Injury	
Phone ()		Referred by:				

Accident? Yes <input type="checkbox"/> No <input type="checkbox"/> / Auto <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/>	Employment Status: Employed <input type="checkbox"/> Student <input type="checkbox"/> (F/T-P/T)
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Employer	Occupation	Work Phone ()	-
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Nearest Relative/Friend Not Living with You	Phone ()	-
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Spouse Name	Spouse Employed by:	Phone ()	-
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Insurance Information

Medical Ins. Co. #1

Social Sec. # Of Insured	-	-	Policy# or Group#	Relationship to patient
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Insured's Name	Authorization:
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DOB of Insured	Employer	Insurance Name
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Address	City	St	Zip	Phone ()	-
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Medical Ins. Co. #2

Social Sec. # Of Insured	-	-	Policy# or Group#	Relationship to patient
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Insured's Name	Authorization:
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DOB of Insured	Employer	Insurance Name
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Address	City	St	Zip	Phone ()	-
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Attorney? Yes <input type="checkbox"/> No <input type="checkbox"/>	Attorney Name:	Phone ()	-
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Auto/Work Comp Ins. (Name/Address)

Adjuster Name	Phone ()	-
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I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING MEDICAL GROUP, INC** I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature _____ Date _____

PLAIN FILM RADIOGRAPHY (X-RAY) PATIENT CLINICAL HISTORY

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____

PROCEDURE _____

REFERRING PHYSICIAN: _____

ADDITIONAL COPY OF REPORT TO WHOM? _____

1. Chief complaints/Reason for exam? _____

2. How long have you had this problem? _____

3. Have you had any surgeries? YES NO

If yes, describe surgeries and give dates. _____

4. Have you had any radiology exams or other tests for this problem, or other problems?

YES NO

If yes, please list dates, tests, and results, if you know. _____

5. Are you pregnant, or might you be? YES NO

6. Date of last menstrual period? _____