MADISON
Radiological Group

401 Baptist Drive, Suite 105, Madison, MS 39110
Office: (601) 499-2010 Fax: (601) 499-2019

Today's Date: _____/_____/_____

PATIENT INFORMATION

MRN: _____

Name: _____ Sex: F M
(Last) (First) (Middle) (Circle)

DOB: _____/_____/_____ SSN: _____/_____/_____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____
(Street / Apt #) (City) (State) (Zip)

Responsible Party: _____ Phone: _____
(If different than patient) (Name) (Relation)

Address: _____
(If different than patient) (Street / Apt #) (City) (State) (Zip)

Is your visit today related to an injury or accident? YES NO If yes, provide the injury date. _____/_____/_____

PRIMARY INSURANCE

Insurance Company: _____
Policy: _____
Group: _____
Policy Holder's Name: _____
DOB: _____/_____/_____ SSN: _____/_____/_____
Relationship to Patient: _____
Pre-Authorization: _____

SECONDARY INSURANCE

_____
_____
_____
_____
DOB: _____/_____/_____ SSN: _____/_____/_____
_____
_____

I authorize any holder of medical or other information about me to release to the Social Security Administration or other insurance carriers any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Radiological Group, P.A. & Madison Radiological Group, LLC.

I attest that I do NOT have medical insurance coverage at the time of service. _____ (Initial if applicable.)

X _____ _____ _____
Patient Signature (If a minor, signature of legal guardian and relationship.) Printed Name Date

- I authorize and give consent for Madison Radiological Group, LLC to contact me by telephone to remind me of my appointments.
- I understand that my insurance policy is a contract between the insurance company and myself and that I am responsible for any limitations within my policy. I hereby agree to accept responsibility of payment for all services my insurance company may deny for any reason, including but not limited to, "Not Medically Necessary", "Non Covered Service", and/or "Not Pre Authorized".

X _____ _____ _____
Patient Signature (If a minor, signature of legal guardian and relationship.) Printed Name Date

Please return the completed form, along with your ID and insurance cards to the receptionist.