Northwest Diagnostic

Patient Information

Please fill out the following patient information completely. Thank You.

Legal Last Name | Legal First Name | M.I. | Nickname | ○ M ○ F Gender | Date of Birth

Street Address | City | State | Zip | Social Security #

( ) Home Phone # | ( ) Cell Phone # | ( ) Work Phone # | x Ext | ○ H ○ C ○ W Primary #

Driver's License # | E-mail Address | ○ S ○ M ○ D ○ W Marital Status | Race | Ethnic Group

Pharmacy Name | ( ) Pharmacy Phone # | Pharmacy Location

Are you a new patient? ○ Y ○ N Is this a work related injury? ○ Y ○ N Is this visit due to an accident? ○ Y ○ N

☐ Employed (○ Full ○ Part ○ Self) ☐ Student (○ Full ○ Part) ☐ Retired ☐ Active Military Duty

Employer | Position/Title | Employer's Street Address

Emergency Contact Last Name | First Name | M.I. | Relation to Patient | ( ) Emergency Contact Phone #

Do you have medical insurance? ○ Yes ○ No If yes, please complete the section below completely.

Primary Medical Insurance and Policy Holder Information

Primary Insurance Company | Policy/Identificaton # | Group # | ○ PPO ○ HMO ○ POS ○ MDC ○ EPO Plan Type

Copay | Effective Date | ( ) Benefits Phone # | Claims Address | City | State | Zip

Policy Holder Legal Last Name | Legal First Name | M.I. | Relation to Patient | ○ M ○ F Gender | Date of Birth

Street Address | City | State | Zip | Social Security #

( ) Home Phone # | ( ) Cell Phone # | ( ) Work Phone # | x Ext | ○ H ○ C ○ W Primary #

Employer | Position/Title | Employer's Street Address

IF YOU HAVE SECONDARY INSURANCE, COMPLETE THE REVERSE SIDE OF THIS PAGE.

I request that payment of authorized insurance benefits be made on my behalf to Northwest Diagnostic Clinic for any services furnished. I authorize Northwest Diagnostic Clinic to release to the insurance company listed above any medical information about me or my dependent which may be needed to determine these benefits or the benefits payable for related services; this may be sent via written or electronic record. A photocopy of this assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by insurance. In addition, I am hereby notified that if I do not show for a scheduled appointment or fail to cancel an appointment, a no show will be noted on my account, and I will be charged a fee of $25.00. The clinic requires a 24-hour notice for all cancellations or reschedules. With three no shows, I may be terminated from the practice. I understand that this office holds my medical records in strict confidence. They will not be released to anyone without my explicit written permission. All requests for the release of medical records must be in writing. A reasonable fee may be charged for the compilation of medical records.

_____ Patient or Guarantor** Signature | Guarantor Name | Date

****Guarantor is the adult who completes this form and is responsible for payment. If the guarantor is different from the insurance policy holder, please complete the guarantor information section on the reverse side of this page.**