# CYPRESS WOMEN'S IMAGING

Date________________ Referring Physician__________________________________

| PATIENT | | SUBSCRIBER'S NAME | |
|---|---|---|---|
| FIRST NAME (Please Print) | Middle Initial | FIRST NAME (Please Print) | Middle Initial |
| LAST NAME | | LAST NAME | |
| STREET ADDRESS | | STREET ADDRESS | |
| CITY, STATE | ZIP CODE | CITY, STATE | ZIP CODE |
| HOME PHONE | WORK PHONE | HOME PHONE | WORK PHONE |
| SOCIAL SECURITY NUMBER | | SOCIAL SECURITY NUMBER | |
| EMPLOYER | OCCUPATION | EMPLOYER | OCCUPATION |
| SEX | MARITAL STATUS | SEX | MARITAL STATUS |
| BIRTHDATE | AGE | BIRTHDATE | AGE |

RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ____________________

NAME, ADDRESS AND PHONE OF PERSON NOT LIVING WITH YOU, TO CONTACT IN CASE OF EMERGENCY

## INSURANCE INFORMATION

| PRIMARY INSURANCE CO. | SECONDARY INSURANCE CO. |
|---|---|
| ADDRESS | ADDRESS |
| INSURANCE I.D.# | INSURANCE I.D.# |
| SUBSCRIBER'S NAME | SUBSCRIBER'S NAME |

IS INJURY A RESULT OF CAR ACCIDENT? __________________________
(If yes, give name & address of auto carrier in above spaces)

IS X-RAY FOR WORKMANS COMPENSATION?________________________

IF YES, GIVE DATE OF INJURY ____________________________________

GIVE A BRIEF HISTORY OF YOUR ILLNESS:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby assign and authorize for direct payment for radiological and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance.

Signed Date

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Wichita Radiological Group to release any information acquired in the course of my examination or treatment to my referring doctor and/or insurance company.

Signed Date

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

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