Cypress Women's Imaging  *Imaging Center at Cypress*

Date_____ Referring Physician_____

PATIENT		SUBSCRIBER'S NAME	
FIRST NAME (Please Print) Middle Initial		FIRST NAME (Please Print) Middle Initial	
LAST NAME	EMAIL	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	CELL PHONE	SOCIAL SECURITY NUMBER	CELL PHONE
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			
GIVE A BRIEF HISTORY OF YOUR ILLNESS:			

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 _____

ACKNOWLEDGMENT OF RECEIPT OF OF PRIVACY NOTICE
I acknowledge that I have been offered/received a copy of the Provider's Notice of Privacy Practices with the effective date of April 28, 2003.

_____ has permission to obtain my medical records. Signed Date

AUTHORIZATION TO OBTAIN MEDICAL RECORDS:
I hereby authorize Wichita Radiological Group to obtain any and all of my medical records.

Signed Date

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