Patient Information

Patient Name: ________________________________ Date of Birth: ____/____/____

Address: ____________________________________City: _____________________

State: _________ Zip: _____________________ Sex: M / F

Home # _______________ Work # _______________ Cell #____________________

SS# ______________________ E-mail _____________________________________

Marital Status: Single / Married / Separated / Divorced / Widowed

Is the patient a student? Y / N Name of School ____________________________

Is the patient working? Y / N Full Time / Part Time

Employer's Name: __________________________ Phone # ___________________

ଓ ***Is this a workers compensation claim?*** ☐ **YES** ☐ **NO**

Emergency Contact: ______________________ Relationship: _________________

1st Phone ____________ 2nd Phone ______________3rd Phone _________________

Policy Holder's Information

Please complete this section only if the patient is not the policy holder.

Name: _____________________________ Relationship to patient: ______________ DOB: ___________

Home # ______________________Work # _______________________ Cell # ___________________

Address: ____City: _______________________

State: _____________________ Zip: ______________ SS # _________________________________

Employer: ____ Phone # ____________________

Payment is required at the time services are rendered. We wish to notify you that Dr. Mehta has ownership/interest in First Diagnostic Imaging Services, Quantum Diagnostic Imaging and Plano Surgery Center and shares in the profits in part from payments made by patients who may be referred to these facilities. You are under no obligation to use these facilities and are free to choose another facility if you so desire.

I authorize payment of medical benefits by my insurance policy to the attending physician. I understand that I am responsible for the balance on this account regardless of insurance coverage.

Signature____ **Date** ___________________