BEAR MRI
AND IMAGING CENTER

PERSONAL INFORMATION (PAGE 1)

(Please present your driver's license or other photo ID and *all Insurance documents for photocopying)*

Name: _____ DOB: _____
Sex: M F

Social Security Number: _____ Marital Status: S M D W

Address_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Email: _____

Employer Name: _____ Phone #:_____

Referring Physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

PRIMARY INSURANCE INFORMATION

INS COMPANY: _____ ID #:_____ GROUP #: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DOB: _____ SOCIAL SECURITY #: _____

Person Responsible for Payment (if not the patient)

Name: _____ DOB: _____ Social Security # ____- ___-_____

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Cell:_____

Relationship to Patient: _____

Employed by: _____ Employer Phone: _____

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PERSONAL INFORMATION (PAGE 2)

SECONDARY INSURANCE INFORMATION

INS COMPANY: _____ ID #:_____
GROUP #: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DOB: _____ SOCIAL SECURITY #: _____

I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND ACCURATE.

PATIENT SIGNATURE (or Parent if a minor) _____

DATE: _____