PATIENT INFORMATION FORM

IMC - DIAGNOSTIC AND MEDICAL CLINIC

Insurance: (1) Insurance: (2) Insurance: (3) Patient No: Type:	User I.D. Dr. Name: FC Desc.

PATIENT HISTORY

Last Name				First Name					
Address-First Line				Address-Second Line					
City and State								Zip Code	
Phone Number	Soc. Sec. No.	Birth Date	Age	Sex	Type	Dr. No.		Race	Marital Status
Employer				Employer's Phone					
Referring Doctor	Emergency Contact / Relationship / Phone							Accident Date	

RESPONSIBLE PARTY

Responsible Party - Last Name	Responsible Party - First Name
Address-First Line	Address-Second Line
City and State	Zip Code

INSURANCE INFORMATION

Ins. Co. No.	Insurance Company Name	Group Name or Number	Policy / Contract No.				
Insured's Name		Effective Date	Relation	Assign			
Ins. Co. No.	Insurance Company Name	Group Name or Number	Policy / Contract No.				
Insured's Name		Effective Date	Relation	Assign		Auto File	
Ins. Co. No.	Insurance Company Name	Group Name or Number	Policy / Contract No.				
Insured's Name		Effective Date	Relation	Assign		Auto File	

COMMENTS

PATIENT'S RESPONSIBILITY: I hereby authorize the release of any medical information necessary to process this claim and I authorize payment directly to your office for services rendered. I also understand that I am financially responsible for these charges.

Signed: _____ Date: _____