Advanced Fullerton Imaging Inc.

Patient Information Sheet

Name: ______________________ Date: ______________

Address: ______________________ Home Phone: ______________

City: ______________ Cell Phone: ______________

Zip: ________ Sex: ______ Soc.Sec#: ______________ D.O.B: __________ Age: ________

Email Address: ______________________ Marital Status: ______________

Spouses Name: ______________________ D.O.B: ______________

Patients Employer: ______________________ Occupation: ______________

Employers Address: ______________________________________

City: ______________ State: ________ Zip: ________ Work Phone: ____________

EMERGENCY CONTACT: ______________________ Phone: ______________

<u>Party responsible for account(If Work Comp.Or Auto provide that information)</u>

Name: ______________________ Relationship To Patient: ______________

Address: ______________________ Home Phone: ______________

City: ______________ Ca: ________ Zip: ________ D.O.B ____________

Responsible Person's Employer: ______________________ Phone: ______________

City: ______________ State: ________ Zip: ______________

Primary Insurance: ______________________ Phone: ______________

ID# ______________________ Group#: ______________

By my signature below,I hereby specifically authorize the physician and/or his agents to provide medical treatment to me.I also authorize AFI Inc. to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims,or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician,realizing that I am responsible for any amount not covered/paid my my insurance.I also authorize the practice to release any medical information or insurance information that requested by any physical therapy,diagnostic imaging or clinical research facility that the practice refers me to as part of my treatment.

Patient(Guardian)Signature: ______________________ Date: ______________