

Patient Insurance Information

First Name	MI	Last Name	___M	___F
Street Address		City, State, Zip Code		
Home Phone Number		Work Phone Number		
Patient's Date of Birth		Patient's SSN		

Primary Insurance

Insurance Company Name	Insurance Company Phone Number
ID Number	Group Number
Policyholder	Relationship
Policyholder's Date of Birth	Policyholder's SSN
Insurance Company Address	City, State, Zip Code

Secondary Insurance

Insurance Company Name	Insurance Company Phone Number
ID Number	Group Number
Policyholder	Relationship
Policyholder's Date of Birth	Policyholder's SSN
Insurance Company Address	City, State, Zip Code

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of payment for today's visit: ___Cash ___Check ___Visa/MC

I authorize the release of any medical information necessary to process my claim.

Signed: _____ Date: _____

I authorize payment of medical benefits to Coastal Radiology.

Signed: _____ Date: _____