☐ 315 W. WENDOVER AVENUE
GREENSBORO, NC 27408
TEL 336.433.5000

☐ 301 E. WENDOVER AVENUE, SUITE 100
GREENSBORO, NC 27401
TEL 336.433.5000

DATE				PATIENT'S SOCIAL SECURITY NUMBER
PATIENT'S NAME LAST		FIRST		MIDDLE
PATIENT'S MAILING ADDRESS		**CITY**		**STATE ZIP**
BIRTHDATE	SEX M F	HOME PHONE		CELL PHONE
MARITAL STATUS (Circle One) M S D W Sep.			REFERRING PHYSICIAN	
EMPLOYER		ADDRESS		WORK PHONE

INSURANCE INFORMATION

NOTE: If you are carried on the insurance of a spouse or parent or other, please fill in the information below. If you are carrying your own insurance - disregard this section.	SOCIAL SECURITY NUMBER
INSURED'S NAME, ***(This is the employee or person who carries the insurance.)***	DATE OF BIRTH
EMPLOYER NAME	EMPLOYER PHONE

AS A COURTESY TO OUR PATIENTS, OUR BILLING STAFF WILL FILE YOUR INSURANCE AND HELP YOU RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER YOUR POLICY. IN MOST CASES, INSURANCE DOES NOT COVER THE FULL COST OF RADIOLOGY (X-RAY) PROCEDURES. IT IS DESIGNED TO REDUCE YOUR COST BUT NOT ELIMINATE IT COMPLETELY. THE PATIENT OR RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE, REGARDLESS OF YOUR INSURANCE COVERAGE.

A) I authorize release of medical information:
1) – to process insurance claims
2) – to or from referring physicians, relevant to my care
3) – for the insurance payment to be paid directly to Greensboro Imaging
4) – by courier to physicians or other facilities relevant to my care

B) I assume financial responsiblity for services rendered as patient or responsible party for the patient named above.

C) I have read this release and understand and accept the terms shown by my signature below.

Signature ____ Date: ____________________

Print Name: ____ Relationship to Patient: ___________________

Payment is expected at the time of service. Check, Cash, Mastercard and Visa are accepted.

WORKER'S COMPENSATION INJURY INFORMATION

PATIENT'S NAME	DATE OF INJURY
DESCRIPTION OF INJURY:	
NAME OF COMPANY EMPLOYED BY AT TIME OF INJURY:	
EMPLOYER'S ADDRESS: CITY STATE ZIP	
NAME OF IMMEDIATE SUPERVISOR YOU REPORTED THE INJURY TO:	EMPLOYER'S PHONE:
INSURANCE CARRIER	CLAIM NUMBER
INSURANCE CARRIER ADDRESS	DATE OF INJURY