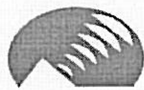

SUMMIT
radiology

DEMOGRAPHICS

Last Name: ______________________

First Name: ______________________

Middle Initial: ______________________

Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Home Phone: ______________________

Cell Phone: ______________________

Work Phone: ______________________

Date of Birth: ______________________

SS # : ______________________

Marital Status: ______________________

EMPLOYER

Employer Name: ______________________

Employer Address: ______________________

Employer City: ______________________

Employer State: __________ Zip Code: __________

GUARANTOR (FINANCIALLY RESPONSIBLE)

Last Name: ______________________

First Name: ______________________

Relationship to Patient: ______________________

Home Phone: ______________________

Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Cell / Work Phone: ______________________

EMERGENCY CONTACT

Last Name: ______________________

First Name: ______________________

Relationship to Patient: ______________________

Home Phone: ______________________

Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Cell / Work Phone: ______________________

INSURANCE INFORMATION

Primary Health Insurance Name (ex: BCBS, ECOH, Medicare) : ______________________

***Who is the primary policyholder for this insurance (If other than yourself, please fill in below)

Policyholder's Last Name: ______________________

Policyholder's First Name: ______________________

Relationship to Patient: ______________________

Policyholder's DOB: ______________________

Policyholder's SSN: ______________________

Secondary Health Insurance Name (ex: BCBS, ECOH, Medicare) : ______________________

***Who is the primary policyholder for this insurance (If other than yourself, please fill in below)

Policyholder's Last Name: ______________________

Policyholder's First Name: ______________________

Relationship to Patient: ______________________

Policyholder's DOB: ______________________

Policyholder's SSN: ______________________

SIGNATURE & DATE

Patient Signature: ______________________ Date: __________

Parent/Legal Guardian Signature: ______________________ Date: __________