O'SULLIVAN RADIOLOGY

Breast, Bone & Body Digital Imaging
6915 N. Main St., Victoria, Texas 77904
361-572-3139 fax 361-572-8610

DATE_____ DOLV_____ PATIENT ID_____

PAYMENT IS REQUIRED AFTER COMPLETION OF EXAM OR X-RAY(S). IF YOU WOULD LIKE US TO FILE WITH YOUR INSURANCE,* YOU WILL NEED TO PROVIDE US WITH A COPY OF YOUR CURRENT INSURANCE CARD AT THE TIME OF SERVICE. ** WE ALSO NEED A COPY OF YOUR DRIVERS LICENSE FOR COMPLIANCE REGULATIONS.*

I INTEND TO PAY BY: CHECK_____ CASH_____ CREDIT CARD_____ INSURANCE_____

Patient's Name Last_____ First_____ MI____ Age_____ SS#_____

Mailing Address_____ City_____ Zip_____ Home Phone #_____

E-Mail_____ Cell Phone #_____

Date of Birth_____ Sex_____ Single___ Married___ Widowed___ Divorced___ Other___

Employer Name, Address & Phone_____

Spouse Name_____ Spouse SS#_____

Spouse Employer Name, Address & Phone_____

If Pt is a child: Father_____SS#_____Employer_____
Mother_____SS#_____Employer_____

REFERRING DOCTOR_____ EXAM REQUESTED_____

REASON_____

Next of Kin_____ Phone _____

Primary Insurance Carrier:_____

Name of Insured_____ DOB of Insured_____

Insured's Employer Name & Address_____Phone_____

Secondary Insurance Carrier:_____

Name of Insured_____ DOB of Insured_____

Insured's Employer Name & Address_____Phone_____

ASSIGN & RELEASE: I hereby authorize payment of medical benefits to this Physician, Sean K. O'Sullivan, MD, for the services described above. I also authorize the release of any information necessary to process this claim.

SIGNATURE:_____DATE:_____