O'SULLIVAN RADIOLOGY

DATE_____ 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.**

Patient's Name: Last_____ First_____ MI___ Age____ Sex_____

Mailing Address_____ City_____ State _____ Zip_____

Home Phone_____ Cell Phone_____ SS#_____

E-Mail_____ DOB_____

Patient Information:

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 Policy Holder_____ DOB of Policy Holder_____

Insured's Employer Name & Address_____

Phone_____

Secondary Insurance Carrier: _____

Name of Policy Holder_____ DOB of Policy Holder_____

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:**_____