Windsor Imaging

4805 NORTH DIXIE HIGHWAY FT.LAUDERDALE, FL 33334
phone: 954-771-6400
fax: 954-771-6499

PATIENT INFORMATION

(**PLEASE PRINT**)

DATE: ______________ PATIENT WEIGHT: ________________________

Patient's Name: ____ SS# _____________________________

Sex ____ Age ____ Date of Birth_________________ Marital Status ________________

Local Address: ____ Phone: ________________________

____Referring Physician_________________________________
(City) (State) (Zip)

Out of state address: ____Phone________________
Patient's Employer: _____________________________________ Occupation __________________
Employer's Address: _____________________________________ Bus Phone __________________
Spouse Name: ____ SS # _______________________
Spouse Employer: _______________________________________ Occupation __________________
Employer Address: ______________________________________ Bus Phone __________________
Nearest Relative (not living in household) ____
Address: ____

Illness or Injury related to: Work _____ Auto Accident _____ other _____ Not Accident Related__________
If yes: Date of Accident ________________ Attorney Name______________________ Phone _____________
Do you authorize Windsor Imaging to send all financial information to the Attorney named above? ________

INSURANCE INFORMATION: **MUST HAVE INSURANCE CARD**
1st Insurance Company: ____________________________Address_____________________________________
Phone_____________________ ID ____Group______________
Policy No______________________________ Insured____
Relation to Insured (check one): Self____ Spouse ____Child_____ Other_____
2nd Insurance Company: ____________________________Address_____________________________________
Phone__________________________ID___________________________________Group________________
Policy No_______________________________Insured____
Relation to Insured (check one): Self____ Spouse ____Child_____ Other_____

AUTHORIZATIONS:
I hereby authorize Windsor Imaging to release any information acquired in the course of my treatment to my insurance company. I request that payment of authorized benefits be made either to me or on my behalf for any services furnished me by Windsor Imaging. **(MEDICARE PATIENTS)** I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

DATE: ______________ SIGNATURE: ____________________ WITNESS ________________________