Park Meadows Imaging

NEW-PATIENT INFORMATION

GENERAL INFORMATION

1. Last Name: _____ First Name:_____MI:__ M ○ F
   Address: _____ City:_____, State:_____ Zip Code: _____
   SSN: _____ DOB: _____/_____/_____
   Please indicate phone number(s) where Park Meadows Imaging staff may leave messages pertaining to appointment times, prescription information, and/or other Private Health Information.
   Home Phone: _____ Msg OK? Y N ○ Emergency Contact: _____
   Work Phone: _____ Msg OK? Y N ○ Relationship: Friend
   Cell Phone: _____ Msg OK? Y N ○ Phone: _____
   Email: _____
   What is your preferred method of contact for an appointment reminder? e-mail ○ text ○ voice message

2. **Referring Physician:** _____ **Phone:** _____

3. **Is this visit due to a/an:** __ Auto Accident ○ Work-related injury ○ Other injury ○ No injury
   Date of Injury/onset of symptoms: _____/_____/_____
   (If you are unsure of the exact date, give the best guess of month and year)

4. **Occupation:** _____ **Employer:** _____ **Phone:** _____

INSURANCE INFORMATION

1. **Primary Insurance Company:** _____ Phone#: _____
   Claims_ Address: _____
   ID/Claim#: _____Grp/Policy#:_____ Insured's Name: _____
   Insured's SSN: _____ lnsured's DOB: _____/_____/_____

2. **Other Insurance Company**: _____ Phone#:_____
   Claims_ Address: _____
   ID/Claim#: _____ Grp/Policy#:_____ Insured's Name: _____
   Insured's SSN: _____ lnsured's DOB: _____/_____/_____

3. **Have you retained an attorney or will you be retaining an attorney?** YES ○ NO
   If yes, please provide name, complete address and phone number below.

   Atty Name: _____ Phone#: _____
   Atty Address: _____

I hereby authorize this facility and/or its clinical staff to perform examinations and treatment as necessary for my care.
Patient Signature: _____ Date: _____/_____/_____

_____	_____	_____
Patient Last Name	Patient First Name	MR#

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