SOUTH ATLANTA RADIOLOGY ASSOCIATES

Have you had any procedures in this office before? NO YES When:____

PATIENT:_____SSN:_____
LAST FIRST MIDDLE
ADDRESS:_____APT:_____
CITY:_____ STATE:_____ZIP:_____
HOME PHONE:_____WORK/CELL:_____

DATE OF BIRTH:_____ SEX:___ MARITAL STATUS: M S D W

ALLERGIES: _____
MEDICATIONS: _____

DO YOU SMOKE? _____If so, how long? _____
ETHNICITY: WHITE AFRICAN AMERICAN AMER.INDIAN
ASIAN HISPANIC OTHER:_____

LANGUAGE:_____ EMAIL ADDRESS:_____

EMPLOYER NAME:_____PHONE:_____
ADDRESS:_____CITY:_____ZIP:_____

REFERRING PHYSICIAN:_____

****NOTICE**IF YOU HAVE NO INSURANCE OR NO PROOF OF INSURANCE COVERAGE, PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE. THANK YOU.**

INSURANCE:_____
POLICY HOLDER:_____RELATIONSHIP:_____
ADDRESS:(IF DIFFERENT THAN PATIENT NFO.)_____
PHONE:_____DOB:_____SS#_____

EMPLOYER NAME/PHONE:_____

I have reviewed a copy of South Atlanta Radiology Associates (SARA) Notice of Privacy Practices. I hereby authorize SARA to release any information in my examination to any insurance or physician(s) providing benefits, treatment or other policies in the course of my examination. I hereby with my signature assign & authorize my insurance carrier(s) to make payment directly to SARA for ALL my services rendered at this facility. I hereby, with my signature, understand that I am ultimately responsible for payment in full of services rendered in the event my insurance carrier or managed care plan denies payment in full or in part for any services rendered, including but not limited to all co-payments and/or deductions, non-covered services and supplies obtained during the course of care

SIGNED:_____DATE:_____