Complete Women's Imaging, P.C.

990 Stewart Ave. Ste.100 Garden City NY 11530

DEMOGRAPHIC DATA

Patient Name:	Date of Birth:		Gender:	Marital Status: M D S W
Address:	City:	State:	Zip:	Social Security #:
Home Phone:	Work Phone:		Cell Phone:	Email Address:
Referring MD Name:	Phone #		Fax #	
Emergency Contact Name:	Relationship:		Phone #	

INSURANCE INFORMATION

Primary Insurance:	Policy #	Group #
Policy Holder Name:	Date of Birth:	Relationship to Patient:
Employer Name:	Phone #	Fax #
Secondary Insurance:	Policy #	Group #
Policy Holder Name:	Date of Birth:	Relationship to Patient:
Employer Name:	Phone #	Fax #

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize Complete Women's Imaging, PC to discuss my health information with the following personal representatives:

_________ *None*

Name	Relationship	Phone Number
Name	Relationship	Phone Number

APPOINTMENT COMMUNICATIONS

I authorize Complete Women's Imaging PC to call me at the following phone number(s) to communicate information about my appointments:

Phone Number (1) Phone Number (2)

I authorize Complete Women's Imaging PC to contact me at the following email address to communicate information about my appointments:

Email Address

COMMUNICATIONS REGARDING PAYMENT OR OTHER FINANCIAL INFORMATION

I authorize Complete Women's Imaging PC to call me at the following phone number(s) to communicate information about payment or other financial information :

☐ leave detailed message
☐ leave message to call back

Phone Number (1)

☐ leave detailed message
☐ leave message to call back

Phone Number (2)

I authorize Complete Women's Imaging PC to contact me at the following email address to communicate information about my payment or other financial informaiton:

☐ leave detailed message
☐ leave message to call back

e-mail address

I CONFIRM THAT, AS OF THIS DATE OF SERVICE, THE ABOVE MENTIONED INFORMATION IS CORRECT.
I understand that changes to the above information must be made in writing.

Patient Signature Date

Patient Representative Relationship to patient

Revision Date: 1/30/2015