Account #______________

PERSONAL INFORMATION

Date________________

PLEASE PRINT

Name	First	Middle Initial	Last			Date of Birth		Age
Social Security Number						Female		Male
Address								
City				State		Zip code		
Phone	Home	( )	Work	( )		Cell	( )	
Emergency Contact	Relationship					Phone	( )	
Marital Status	Single ☐	Married ☐	Separated ☐	Divorced ☐		Widowed ☐		
Spouse's name								

PHYSICIAN INFORMATION

Ordering Physician:			
(First)	(Last)	(MD/DO/DC)	Phone
			( )
Would you like anyone else to receive a copy of this study report? If so, please complete:			
Name			( )
Address			

INSURANCE INFORMATION

Primary Medical Insurance			Effective Date			
Policy Number			Group Number			
Insurance provided through:	Your employer ☐		Spouse's employer ☐		Other ☐	
If other than self, list information for the primary card holder:						
Name		SS#		Date of Birth		
Employer name						

Second Medical Insurance			Effective Date			
Policy Number			Group Number			
Insurance provided through:	Your employer ☐		Spouse's employer ☐		Other ☐	
If other than self, list information for the primary card holder:						
Name		SS#		Date of Birth		
Employer name						

Patient Signature ____________________________ or Signature of patient's representative____________________________

(Relationship: __ Parent (minor under 18 years) __Court appointed Guardian)

Date _________________

Fax to Premier MRI/CT: 800.792.6950

Please complete information below if injury related to Work, Auto or other known injury

Is this a **WORK** related injury?		Yes ☐ No ☐
If yes:	Date of injury:	
Employer you worked for when injured:		

Is this an **AUTO** related injury?		Yes ☐ No ☐
If yes:	Date of injury:	

Is this **another type** injury?		Yes ☐ No ☐
If yes:	Date of injury:	
Where did injury take place?		
How were you injured?		

Claim number:							
Send bills to:				**Caseworker:**			
Insurance				Name			
Address				Address			
City				City			
State		Zip		State		Zip	
Adjuster				Phone	( )		
Phone	( )						

Is there a lawsuit involved?	Yes ☐ No ☐

IF yes, please provide attorney information

Name	
Address	
Phone	( )