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ROBERT P. HENDERSON, M.D., F.A.C.R. (Emeritus)

RECORD NO.

PATIENT INFORMATION

PATIENT NAME LAST | FIRST | MIDDLE INITIAL | SOCIAL SECURITY NO.

STREET ADDRESS | CITY | STATE | ZIP CODE

P.O. BOX | CITY | STATE | ZIP CODE

( ) HOME PHONE NO. | ( ) CELL PHONE NO.

DATE OF BIRTH | AGE | SEX | MARITAL STATUS | WHO REFERRED YOU

PATIENT'S EMPLOYER | EMPLOYER'S PHONE NO.

EMPLOYEE'S STREET ADDRESS | MAILING ADDRESS | CITY | STATE | ZIP CODE

SPOUSE'S NAME | SPOUSE'S EMPLOYER | PHONE NO.

IF PATIENT IS MINOR OR STUDENT

GUARANTOR'S NAME | ADDRESS, CITY, STATE AND ZIP | PHONE NO.

GUARANTOR'S EMPLOYER | ADDRESS, CITY, STATE AND ZIP | PHONE NO.

INSURANCE INFORMATION

PRIMARY INSURANCE | I.D. NO. | GROUP NO. | ADDRESS, CITY, STATE AND ZIP

INSURANCE PHONE NO. | INSURED NAME | INSURED DATE OF BIRTH

SECONDARY INSURANCE | I.D. NO. | GROUP NO. | ADDRESS, CITY, STATE AND ZIP

INSURANCE PHONE NO. | INSURED NAME | INSURED DATE OF BIRTH

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or other insurance carriers any information needed for this or a related Medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Radiological Group, P.A.

SIGNATURE OF PATIENT X____________________ DATE__________

I hereby give permission for my insurance Company to pay Radiological Group, P.A. directly. I further agree to pay any balance due and payable.

I agree to accept responsibility for payment for all Services Provided by Radiological Group which my Insurance Company may deny payment for reason of "Services not Medically Necessary/Not Covered."

X____________________