

# MADISON RADIOLOGICAL GROUP LLC

401 BAPTIST DRIVE SUITE 105  
MADISON, MISSISSIPPI 39110  
PHONE: (601) 499-2010  
FAX: (601) 499-2019

RECORD NO.

05

## 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 Madison Radiological Group LLC or Radiological Group, P.A.

SIGNATURE OF PATIENT X \_\_\_\_\_ DATE \_\_\_\_\_

I hereby give permission for my insurance Company to pay Madison Radiological Group LLC or 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 Madison Radiological Group LLC and Radiological Group P.A. which my Insurance Company may deny payment for reason of "Services not Medically Necessary/Not Covered."

X \_\_\_\_\_