



Welcome to

ADVANCED MEDICAL IMAGING

(PLEASE PRINT)

PLEASE PRESENT ALL MEDICAL CARDS AT TIME OF SERVICE

Name _____ Title: Mrs Miss Ms Mr
Last First Initial

Previous Name: _____

Sex: (Circle one) M F Birthdate: _____ Soc. Sec. #: _____
Mo / Day / Year

Mailing Address: _____
Street City State Zip

Street Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Doctor(s): _____ Who is responsible for your bill?: _____

Primary Insurance: _____ Secondary Insurance: _____

Please give us the following information on the **subscriber** for your insurance: (If subscriber is someone other than yourself)

Name: _____ Birthdate: _____ Soc. Sec. #: _____
Mo / Day / Year

Employer: _____

If there are previous films related to this exam, where were they taken?: _____

IF THIS EXAM IS DUE TO AN ON-THE-JOB INJURY OR A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE BELOW

AMI-05

Is this an on-the-job injury (L&I) claim? If yes, please complete the following:

Date of Injury: _____ Place of Accident: _____

Full Claim Number: _____ Your Employer: _____

Is this a Motor Vehicle Accident? If yes, please complete the following:

Date of Injury: _____ Claim #: _____

Name and address of company and/or person to bill for payment:

