S A R A

SOUTHERN ARIZONA RADIOLOGY ASSOCIATES

PATIENT INTAKE/UPDATE

Patient Name: _____ DOB: _____/_____/_____ Gender:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

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

Email address: _____

If you have been seen at our facility with a different last name please list: _____

Other physicians you would like to receive a report of today's examination(s): _____

Primary Insurance

Insurance Name: _____

If patient is a minor OR If you are not the subscriber for the insurance:

Subscriber's Name: _____ DOB: _____ Subscriber's Sex:_____

Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____

If patient is a minor OR If you are not the subscriber for the insurance:

Subscriber's Name: _____ DOB: _____ Subscriber's Sex:_____

Relationship to Patient: _____

Financial Responsible Party _____ Relationship to Patient:_____

If your examination today is related to an accident was it: □ work □ auto Date of Injury_____

Employer (Name/Address) _____Phone_____

AUTHORIZATION TO PAY:

I hereby authorize payment directly to the business office of Southern Arizona Rad Associates for medical benefits, otherwise payable to me for services.

I understand that I am financially responsible for the charges not covered by my insurance.

_____ **Date: _____/_____/_____**

Patient signature (or legal guardian)