NORTHERN ARIZONA RADIOLOGY

Patient Name:			SS#:	
DOB:	Sex:	Marital Status:		
Mailing Address:	City:	State:	Zip:	
Referring Physician:	Family Physician:			
Check the preferred method of contact below:				
□ Home Phone:	□ Work Phone:			
□ Cell Phone:	□ Email:			
EHR INFORMATION				
Your Preferred Language:	Are you a smoker? Check below one that applies			
Your Race:	□ Current every day smoker			
Your Ethnicity:	□ Current occasional smoker			
Flu Shot? □ yes □ no	□ Former smoker			
When?	□ Never smoked			
RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE				
Name:	Home Phone:	Work Phone:		
Street:	Apt.#:	City:	State:	Zip:
DOB:	SS#:			
Relationship to Patient: (Wife, Husband, Mother, Father, Guardian, Other)				

Authorization: I hereby authorize Northern Arizona Radiology physicians to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. By signing below I also confirm that all information I have provided is true to the best of my knowledge.

_____ _____

Signature Date