NORTHERN ARIZONA RADIOLOGY

Date: Jacket No.

Patient Name:	SS#:		
DOB:	Sex:	Marital Status:	
Mailing Address:	City:	State:	Zip:
Check the preferred method of contact below			
☐ Home Phone:	☐ Work Phone:		
☐ Cell Phone:	☐ Email:		
Referring Physician:	Family Physician:		

EHR INFORMATION

Your Preferred Language:	Are you a smoker? Check one that applies		
Your Race:	Current every day smoker ☐	Former smoker ☐	
Your Ethnicity:	Current some day smoker ☐	Never smoked ☐	
Flu Shot: Yes ☐ No ☐ When?			
Want access to the NAR Patient Portal? Yes ☐ No ☐	Provide email:		

WERE YOU INJURED ON THE JOB? IF SO . . . .

Industrial Claim #	Date of incident:	Insurance Carrier:	
Employer:	Work Phone:		
Work Address:	City:	State:	Zip:

INSURANCE INFORMATION

PRIMARY Ins. Co. Name:			
Insurance I.D. No.:	Group Name or No:		
Billing Address:	Phone:		
Insured Name:	DOB:	Sex: M ☐ F ☐	
SECONDARY Ins. Co. Name:			
Insurance I.D. No.:	Group Name or No:		
Billing Address:	Phone:		
Insured Name:	DOB:	Sex: M ☐ F ☐	

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

Name:	Home Phone:	Work Phone:		
Street Address:	Apt. No.:	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.

_____ _____

Signature Date

NAR130