New Patient Intake / Self-Referral Form

Please complete and return to initiate the scheduling process. Thank you!

Patient Name: _____DOB:____/___/_____ Age:_____ Height: _____ Weight: _____

Emergency Contact: _____ Contact Number: _____ Relationship: _____

Home Address _____

Phone (_____)_____Work Phone (_____)_____ Email: _____

Reason for Exam: _____Occupation: _____ Employer: _____

Is your visit due to a job-related injury or automobile accident? YES ☐ NO ☐

Have You Been to Our Office Before?_____ ☐ Yes ☐ No If Yes, When?

Type of Exam you are here for today: _____

*Referring Physician's Name: _____

Current Symptoms: _____

Allergies: _____

Medications: _____

How Did You Hear About Our Facility? _____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY _____

NAME OF POLICY HOLDER_____ DATE OF BIRTH OF POLICY HOLDER _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

ID NUMBER_____GROUP NUMBER _____

I hereby authorize Sacramento Imaging to release any information to my insurance company acquired in the course of my examination. I hereby authorize benefits to be paid directly to Sacramento Imaging. I understand that I am fully responsible for any unpaid balance, and I understand that my insurance may deny benefits, thus making me responsible for any amount not paid. I also authorize Sacramento Imaging to communicate/transmit test results by means of routine mail, electronic mail or fax transmissions. I permit a copy of this authorization to be used in place of the original.

Authorization to Treat: I give consent to receive services by Sacramento Imaging.

_____

*Signature of Patient or Authorized Representative Date