



1114 Charlevoix Ave. Petoskey, MI 49770

PATIENT DEMOGRAPHICS

Patient Name: _____
(FIRST) (MIDDLE INITIAL) (LAST)

Sex: M F Date of birth: _____ Age: ____ SS# _____ Marital Status: S M D W

CONTACT INFORMATION

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

E-Mail Address: _____ **Primary Care Doctor:** _____

*May we have your permission to e-mail you regarding upcoming imaging center information and events? YES / NO

Emergency Contact: _____ Relationship: _____ Phone Number: _____

PATIENT EMPLOYMENT

Employment status (Please check appropriate box) Full time Part time Unemployed Retired

Employer: _____ Employer Phone Number: _____

INSURED PARTY INFORMATION

Is today's exam related to a **MOTOR VEHICLE ACCIDENT or **WORKER'S COMP CLAIM**? Yes No

PRIMARY INSURANCE

Carrier: _____ Policy # _____ Group# _____

Name on insurance card: _____ Sex: M F Date of birth: _____

Employment: (Please check appropriate box) Full time Part time Unemployed Retired

Employer: _____ Employer Phone Number: _____

SECONDARY INSURANCE

Carrier: _____ Policy # _____ Group# _____

Name on insurance card: _____ Sex: M F Date of birth: _____

RESPONSIBLE PARTY INFORMATION

*** This section must be completed if the patient is 18 years or younger ***

Parent/Guardian Name: _____
(FIRST) (MIDDLE INITIAL) (LAST)

Sex: M F Date of birth: _____ Contact Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____