PLEASE PRINT PATIENT INFORMATION

Patient's Name_____
First Middle Last

Birth Date_____Age_____Sex_____Known Allergies_____

Social Security #_____Marital Status: S M W D
(Circle One)

Home Address_____Home Phone_____

City_____State_____Zip_____

Patient's Employer_____

Business Address_____Zip_____Business Phone_____ext_____

Closest Relative Not
Living at Same Address_____Relationship_____

Address_____City_____State_____Phone_____

Referring Physician_____

If you are Medicare Beneficiary, are you currently a resident of a Skilled Nursing Facility? _____

If yes, which Facility?_____

RESPONSIBLE PARTY INFORMATION:

Responsible Party_____Relationship_____

Mailing
Address_____City_____State_____Zip_____Phone_____

Employer_____

Business Address_____Zip_____Business Phone_____Ext_____

Responsible Party's Spouse_____Employer_____

Business Address_____Zip_____Business Phone_____Ext_____

Insured Date of Birth_____

I,_____, understand that I will receive a separate bill from Lubbock Diagnostic Radiology, L.L.P. for the reading fee of the x-ray(s) taken at this center.

Questions regarding this bill can be directed to:

Lubbock Diagnostic Radiology, L.L.P.
4005 24th Street
Lubbock, TX 79410
(806) 792-2767

_____ _____ _____
Signature Witness Date