Pink Door Imaging

BREAST & GYNECOLOGICAL IMAGING

PATIENT INFORMATION
(PLEASE PRINT)

DATE: ____________

NAME: LAST, FIRST____ **Date of Birth:** ________

Address: ____**City:** ________ **State:** ___ **Zip code**_____

Cell: _____________________ **Email:** ____________________________________

DOCTORS NAME ON YOUR ORDERS_______________________________________

□ Female □Male □Married □Single SS# __________________

(Optional): Ethnicity: ____________ Language: ________________

Current Smoker □Y □N Years_____ Quit Smoking: Year_____ **Drug Allergies:** __________________

In order to process Medical Billing Claims Accurately:

PLEASE FILL OUT ALL NEEDED INFORMATION: (*DO NOT leave Blank*)

□AETNA □ HUMANA □CIGNA □ UNITED HEALTHCARE □BCBS □UMR

Subscriber ID____ Group # ___________________

POLICY HOLDERS NAME: ___________________________________***DOB***__________

Policyholder defined as - (person who carries the insurance policy)

***Relationship to Cardholder*: SELF SPOUSE CHILD OTHER**

Medicare Insurance: Please fill out below

MEDICARE PRIMARY ID#: ________________________ **SECONDARY**______________

RETIRED Y/N Current Employer_______________________________

Emergency Contact Name & PH#____