Pink Door Imaging

BREAST & GYNECOLOGICAL IMAGING

PLEASE PRINT

DATE OF VISIT________

PATIENT NAME: ______________________________ **Date of Birth:** ________

Address______________________**City**________**State**____**Zip**___

ORDERING PHYSCIAN ____________________________

Please "PRINT" Email (will be used future appointment confirmation)

EMAIL: __________________________ **CELL PHONE**__________

□FEMALE □MALE □SINGLE □MARRIED (optional)□ ETHNICITY □LANGUAGE

Current Smoker □YES □NO Years___ Quit Smoking year____ Drug Allergies______

To Process Billing Claims Accurately *(Please fill Out Completely) *

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

Subscriber ID_________________________ Group # ___________

POLICY HOLDERS NAME: ______________________DOB________

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 and Ph#______________________

**************************STAFF USE ONLY**************************************

□SCREENING □ BREAST US □ DX/US (BI/UNI) (BI/BI) (UNI/UNI) **$55 tomo□**

□ PELVIC □ ABDOMEN □ TRANSABDOMINAL □THYROID □BX

CO-INSURANCE AMOUNT_______ 100% COVERED□

BC#______________________ FINAL TOTAL COST_______