

Diagnostic Imaging Specialists of Chicago, P.C.

60 East Delaware Place • Suite 1410 • Chicago, IL 60611

Phone 312-867-9000 • Fax 312-867-9127

DATE _____

NAME _____
LAST NAME FIRST MIDDLE

DATE OF BIRTH _____ AGE _____

HOME ADDRESS _____
CITY/STATE ZIP CODE

HOME PHONE (_____) _____ CELL PHONE (_____) _____

EMAIL ADDRESS _____

OCCUPATION _____ PLACE OF EMPLOYMENT _____

ADDRESS _____ WORK PHONE # (_____) _____

HAVE YOU BEEN TO OUR OFFICE BEFORE? _____ IF YES, WHEN? _____ FOR ULTRASOUND FOR MAMMOGRAM

TYPE OF EXAM YOU ARE HERE FOR TODAY: ROUTINE MAMMOGRAM PROBLEM MAMMOGRAM ULTRASOUND
 BONE DENSITY OTHER _____

IF PREGNANT, PLEASE INDICATE LAST MENSTRUAL PERIOD _____

***REFERRING PHYSICIAN'S NAME** _____
ADDRESS CITY/STATE ZIP CODE

DR. WERBER HAS CHOSEN TO OPT-OUT OF MEDICARE INSURANCE.

DO YOU HAVE MEDICARE? _____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY _____

NAME OF POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT _____

ID NUMBER _____ GROUP NUMBER _____

I hereby authorize Diagnostic Imaging Specialists of Chicago, P.C. to release any information to my insurance company acquired in the course of my examination. I hereby authorize benefits to be paid directly to her. 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 permit a copy of this authorization to be used in place of the original.

(PLEASE BE AWARE THAT SOME INSURANCE PLANS DO NOT COVER ROUTINE EXAMS.)

Signature of Patient or Authorized Representative Date

THERE ARE NO CHANGES SINCE MY LAST VISIT _____
Signature of Patient or Authorized Representative Date