



PATIENT INFORMATION			
SS#:	Last Name:	First Name:	
Middle:	DOB:		
Gender:		Marital Status:	
Address:			
City:	State:	Zip:	
Home Phone () -	Cell Phone () -	Work Phone: () -	
Employer:		Occupation:	
Employer Address:			
City:	State:	Zip:	
PRIMARY INSURANCE			
Insurance Company:	ID#:	Group#:	
SECONDARY INSURANCE			
Insurance Company:	ID#:	Group#:	

ATTENTION ALL MEDICARE PATIENTS. Please list all medical insurance policies that you have in addition to Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize INVIEW MEDICAL IMAGING to release all information necessary to secure payment from my insurance carrier(s) and Medicare (if applicable).

Signed: _____ Date: _____

PATIENT PRIVACY: Our practice is committed to securing the privacy of your health information. Accordingly, we have provided you with a copy of our practice's *Notice of Privacy Practices*. You are not required to read this notice. However, we would like your acknowledgement that you received this *Notice of Privacy Practices*.

Signed: _____ Date: _____

Free Bone Density Screening!

Risk Factors Include: All women 65+, post menopausal women (with additional risk factor), considering therapy for osteoporosis or women who are currently on hormone therapy (HRT/ERT) for prolonged periods.

YES, I'm interested in receiving a free bone density screening.

Join our mailing list. We do not sell or share our email list with any outside companies. Your email address will only be used to deliver news, discounts and announcements pertaining to InView Medical Imaging.

Email: _____

