Important information about your appointment

If you are scheduled for an MRI, CT, or PET-CT our staff will be calling you soon to conduct a medical screening interview prior to you exam to obtain information about your medical history.

If you have not received a call from us by the day before your appointment, or if you have not had the opportunity to return our calls, please call 559.447.4000 so we may conduct your medical screening interview.

On the day of your appointment

- **Insurance card:** Please remember to bring your insurance card with you (we will need photocopies to help ensure accurate and timely billing).
- **Referral form:** Please bring the referral from your physician with you on the day of your appointment.
- **Patient privacy:** To help ensure we provide patient privacy for all of our patients please limit the number of guests you bring.

Section 1: Patient Information

Last Name:	**First Name:**	**Middle Initial:**
Birth Name:		
Mothers Maiden Name:		
Responsible Party:		
Mailing address		
Address:	**Apartment:**	
City:	**State:**	**Zip:**
Primary Phone:		
Secondary Phone:		
Physical address		
Address:	**Apartment:**	
City:	**State:**	**Zip:**
Social Security #:		
Date of Birth:		
Sex:		
Special Needs:		
Marital Status:		

Section 2: Employer Information

Are you employed?

Employer name:

Work phone:

Occupation:

Section 3: Physician Information

Referring physician: (physician who sent you)	
Primary care physician: (family physician)	

Section 4: Spouse Information and Emergency Contacts

Spouse		
Last name:	**First name:**	**Middle initial:**
Date of birth:		
Emergency Contact #1		
Last name:	**First name:**	
Relation to patient:		
Home phone:	**Other phone:**	
Emergency Contact #2		
Last name:	**First name:**	
Relation to patient:		
Home phone:	**Other phone:**	

Section 5: Insurance Information

Primary Insurance		
Is the insurance in your name?		
Last name:	**First name:**	**Middle initial:**
Name of insurance:	**Policy / Subscriber number:**	
Date of birth:	**Sex:**	
Relationship to Policyholder/Subscriber:		
Secondary Insurance		
Last name:	**First name:**	**Middle initial:**
Name of insurance:	**Policy / Subscriber number:**	
Date of birth:	**Sex:**	
Relationship to Policyholder/Subscriber:		

Please make sure to print this form and bring your insurance card with you on the day of your appointment.