CLERMONT RADIOLOGY

FACE SHEET

Please answer all questions fully.

Date:	Account number:

Patient Information

Name (Last, First, MI)	Social Security Number	Age	Date of Birth	Sex	Home Phone Number

Mailing Address	City	State	Zip Code	Marital Status

Email Address			Date of Accident	Claim Number

Responsible Party Information

Name (Last, First, MI)	Social Security Number	Date of Birth	Sex	Home Phone Number

Address	City	State	Zip Code	Marital Status

Employer	City	State	Zip Code	Work Phone Number

Radiologist	Referring Provider	Referring Address	Phone	Fax

Insurance Information

Primary Insurance Company/Auto insurance if applicable	Subscriber's Name, Date of Birth, SSN	Relationship	Policy Number/Group Number	Copay

Second Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy Number/Group Number	Copay

Third Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy Number/Group Number	Copay

Emergency Contact Information

Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Attorney Information (if applicable)

Attorney Name (First, Last Name)	Phone Number	Fax Number

Attorney Address (Street, City, State, Zip)

Do you have medical insurance?

Yes ☐ No ☐ (Check one) If yes, a copy of your health insurance card is needed.

Patient Release

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature:_____ Date: _____

Signature of insured or authorized person, patient or parent if a minor

To report a complaint regarding the services you receive, please call the Agency for Health Care Administration toll free at 1-888-419-3456.
To report abuse, neglect, or exploitation, please call the Florida Department of Children and Families toll free at 1-800-962-2873.