

RADIOLOGY CONSULTATION

CID acct. # _____

CENTRAL ILLINOIS DIAGNOSTICS
3419 N. WOODFORD DECATUR, IL 62526
PHONE 217-875-5656 FAX 217-875-5399

PATIENT INFORMATION

DATE _____ Please check: Group Ins ___ Cash ___ Work Comp ___ Auto acc ___

NAME _____ PHONE _____

ADDRESS _____ CITY/ST _____ ZIP _____

AGE _____ DATE OF BIRTH _____ S.S. # _____

PRIMARY INS _____ POLICY # _____

ADDRESS _____ GROUP NAME/# _____

INSURED'S NAME _____ EMPLOYER _____

RELATIONSHIP: Self ___ Spouse ___ Child ___ Other ___ S.S.# _____

SECONDARY/AUTO INS _____ POLICY # _____

ADDRESS _____ GROUP NAME/# _____

INSURED'S NAME _____ EMPLOYER _____

RELATIONSHIP: Self ___ Spouse ___ Child ___ Other ___ S.S. # _____

ATTORNEY'S NAME _____ PHONE _____

ADDRESS _____

WORK COMP INS _____ CLAIM # _____

ADDRESS _____

EMPLOYER _____ DATE OF INJURY _____

EMPLOYER'S ADDRESS _____

I understand that my doctor is submitting my x-rays for radiologist's interpretation to Dr. C.M.Becker of CENTRAL ILLINOIS DIAGNOSTICS. I authorize the release of medical information so that they can bill my insurance if applicable. I also assign benefits for this service to CENTRAL ILLINOIS DIAGNOSTICS and understand that I am responsible for any unpaid balance due.

PATIENT'S SIGNATURE _____ DATE _____

MEDICARE PATIENTS ONLY: I understand Medicare does not cover this service but my supplemental insurance will be billed if applicable.

PATIENT'S SIGNATURE _____ DATE _____

(Medicare patient's signature is required on both lines above.)