NEW PATIENT

CHEYENNE RADIOLOGY

Email Address: _____ Gender: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Preferred Language: _____ Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Phone: _____

If age 13 and up what is your smoking status:

☐ Never Smoked ☐ Every day smoker ☐ Occasional Smoker ☐ Former Smoker

Nearest Relative not living with you: _____ Phone: _____

Is your visit today for an injury? ☐ Yes ☐ No Date of Injury: _____

RESPONSIBLE PARTY INFORMATION *(Complete for Minors or Legal Guardianship)*

Name: _____ Relation to Patient: _____

Date of Birth: _____ Email Address: _____ Gender: _____

Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Mailing Address: _____

Policy Number: _____ Group: _____

Name of Policy Holder: _____

Policy Holder Birth Date: _____ Relationship to Patient: _____

Secondary Insurance Company: _____

Mailing Address: _____

Policy Number: _____ Group: _____

Name of Policy Holder: _____

Policy Holder Birth Date: _____ Relationship to Patient: _____

WORK COMP CLAIM INFORMATION

Worker's Comp Case Number: _____

Date of Injury: _____ County of Injury: _____

AUTO ACCIDENT CLAIM INFORMATION

Auto Insurance Name: _____ Phone: _____

Auto Insurance Address: _____

Claim Number: _____

Policy Holder's Name: _____

Please list any medication you are currently taking: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any allergies (including drug allergies): _____

_____

_____

_____

_____

_____