SMH Imaging Center℠

PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____

Mailing Address: _____ City _____ State ____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: _____ Social Security#: _____ Marital Status: _____

Smoking Status: ◯ Never Smoked ◯ Former Smoker ◯ Current Smoker

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired Disabled

E-Mail Address: _____

Do you have a living will? ◯ Yes ◯ No

Retirement Date: _____ Spouse Retirement Date: _____ Disability Date: _____

Employer: _____ Student? ◯ Yes ◯ No Race: _____

Religion: _____ Primary Language: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact's DOB: _____ Emergency Contact's Phone #: _____

Name of Primary Insurance: _____

Name of Policyholder (if not self): _____

Policyholder's Employer: _____

Policyholder's Date of Birth: _____ Relationship to Patient: _____

Policy Holder's SSN: _____ Policyholder's Employer's Phone#: _____

Policyholder's Employer's Address: _____

Is your visit today related to an accident? ◯ Yes ◯ No If so, what was date of injury? _____