

COLUMBIA-PRESBYTERIAN EASTSIDE RADIOLOGY
PATIENT DEMOGRAPHIC SHEET
PATIENT INFORMATION

UNIT # _____ **DATE:** _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt. #: _____ City: _____

State: _____ Zip: _____ Social Security #: _____

Home Tel. #: _____ Business Tel. #: _____

Referring M.D.: _____ M.D.'s Tel. #: _____

Doctor's Address: _____

Date of Birth: _____ Sex: Male _____ Female _____

Marital Status: (CIRCLE ONE) Married Single Widow Divorced Separated

Mother's First Name: _____ Father's First Name: _____

Employer: _____ Address: _____

ARE YOU PREGNANT? : (CIRCLE ONE) Yes No

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insured: _____ Relationship to Patient: _____

Insurance Co. Name: _____ Ins. Co. Tel. #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

SS# of Insured: _____ Date of Birth of Insured: _____

Ins. ID#: _____ Policy/Carrier#: _____ Group#: _____

SECONDARY INSURANCE:

Name of Insured: _____ Relationship to Patient: _____

Insurance Co. Name: _____ Ins. Co. Tel. #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Ins. ID#: _____ Policy/Carrier#: _____ Group#: _____

COMPENSATION and/or NO-FAULT INFORMATION

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co Tel. #: _____ ****Claim/Authorization#:** _____

Date of Accident: _____ State of Accident: _____

Attorney/Contact Person: _____ Tel. #: _____