BEXARIMAGING
A WellMed Company

PATIENT INFORMATION

Patient Name ____________________ Last 4 Digits of SSN__________ sex M☐ F☐

Street Address ________________ Date of Birth ________ Marital Status ☐S M☐ W☐ SEP☐ D☐

City/State________________________ Zip ____________ Tel. # ______________________

PERSON TO CONTACT IN CASE OF EMERGENCY

Name ______________________________ Relationship ______________________________

Address ____________________________ City/State ____________________ Zip ________

Home Phone _________________________ Work Phone __________________

INSURANCE

Do you have military healthcare benefits? ☐ Yes ☐ No

#1 Primary Insurance Co. Name _______________ ID # _______ Plan _________ Group ________

Subscriber's Name ____________________ Date of Birth __________ Relationship __________

#2 Secondary Insurance Co. Name ______________ ID # _______ Plan _________ Group ________

Subscriber's Name ____________________ Date of Birth __________ Relationship __________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process any claims. I permit a copy of this authorization to be used in place of an original.

I hereby authorize Bexar Imaging Center to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Bexar Imaging Center.

I certify that the information I have reported with regard to my insurance coverage is correct.

I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group to apply to my account, should a balance exist.

Date: ______________

Signature: ____________________________
(Patient, Parent, Guardian)

Attach copies: Insurance Card/ Driver's License