PLEASE TYPE OR PRINT IN BLACK INK

LRDC Physician: ____________________

For LRDC Use Only
LRDC # ________
LRDC Dr ________
Initially Seen ________
Where ________

PATIENT'S NAME	MARITAL STATUS S / M / W / DIV / SEP	BIRTH DATE	SEX M / F	SOCIAL SECURITY NUMBER

ADDRESS	CITY AND STATE	ZIP	HOME PHONE NO.

EMAIL ADDRESS	CELL PHONE NO.

HAVE YOU EVER BEEN SEEN BY A PHYSICIAN OF THE LITTLE ROCK DIAGNOSTIC CLINIC?	YES	NO	WHEN	WHICH PHYSICIAN

EMPLOYER'S NAME AND STREET ADDRESS

CITY AND STATE	ZIP CODE	BUSINESS PHONE	HOW LONG EMPLOYED HERE

SPOUSE'S NAME	SPOUSE'S EMPLOYER (NAME AND ADDRESS)	BUSINESS PHONE

NAME OF FRIEND OR RELATIVE (NOT LIVING WITH YOU)	RELATIONSHIP	ADDRESS	PHONE NO.

REFERRING DOCTOR INFORMATION

How did you find out about our clinic? ____________________

Referring Doctor: Name ____________ Address ____________ Phone No. ____________

Family Doctor (if different from above): Name ____________ Address ____________

	PRIMARY INSURANCE	SECONDARY INSURANCE	OTHER INSURANCE
INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS			
POLICY HOLDER			
RELATIONSHIP TO PATIENT			
SOCIAL SECURITY NO.			
BIRTH DATE			
SEX M / F			
POLICY CERTIFICATE NO.			
GROUP NO.			
EMPLOYER'S NAME OR SCHOOL NAME			

WE WILL BE GLAD TO HELP YOU FILE FOR INSURANCE BENEFITS. PAYMENT OF YOUR CHARGES SHOULD NOT BE DEPENDENT UPON PAYMENT OF INSURANCE BENEFIT.

I understand I will be responsible for all billable services not covered by insurance.

I authorize the Little Rock Diagnostic Clinic to release medical information necessary to claim reimbursement from insurance companies to whom a claim has been submitted. I understand the Clinic will refund to me promptly any overpayment on my account. This authorization and assignment may be revoked by me at any time by written notice.

Patient or Guardian	Date	Signed by	Relationship