Fairbanks Ultrasound, LLC

Patient Information:

Name: _____ DOB: ____/____/_____ Sex: Male Female

Social Security #: _____ Marital Status: Married Single Widowed Divorced

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Home #: _____ Work #: _____ Cell #: _____

Employer Name: _____ Email: _____

Emergency Contact Name: _____ Contact #: _____

If patient is a Minor, Responsible Party:

Primary Insurance:

Insurance Name: _____

_____

Insurance Address: _____

_____

ID#: _____

Group#: _____

Policy Holder: _____

Relationship to Policy Holder (circle one):

Self Spouse Child

Policy Holders Date of Birth: _____

Policy Holders SS#: _____

Secondary Insurance:

Insurance Name: _____

_____

Insurance Address: _____

_____

ID#: _____

Group#: _____

Policy Holder: _____

Relationship to Policy Holder (circle one):

Self Spouse Child

Policy Holders Date of Birth: _____

Policy Holders SS#: _____

By signing below, you agree to the use and disclosure of our protected health information by Fairbanks Ultrasound, LLC, Jeffrey Zuckerman, M.D., our staff and other business associates for treatment, payment and healthcare operations. Your healthcare information will not be release to any other party without consent from you prior. For a more detailed description of uses and disclosures for these purposes, please review our NOTICE OF PRIVACY PRACTICES. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice simply by contacting our office. ***I hereby authorize Fairbanks Ultrasound, LLC to provide me with diagnostic imaging services as requested by my health care provider.*** *I have read, understood, and agree that I am ultimately responsible for all professional and/or technical fees. I hereby assign payment for all medical benefits including major medical benefits to which I am entitled from private insurance and any other health plans to Fairbanks Ultrasound, LLC. This assignment will remain in effect until revoked by me in writing. I authorize assignee to release all information necessary to secure payment for services.*

Patient Signature (or guardian if minor): _____ Date: _____

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