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[www.xraydoctors.com](http://www.xraydoctors.com)

Doctors Name \_\_\_\_\_  
Date of films \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Cash Insurance Medicare Work Comp PI/Auto PI/Other

**Patient Insurance Information**

*Required Info*                      *Patient*                                      *Insured*  
Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State & Zip \_\_\_\_\_  
Telephone \_\_\_\_\_  
Soc Sec # \_\_\_\_\_  
Age & Sex \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**Relationship to Insured**                      **Self**                      **Spouse**                      **Child**                      **Other**

**Insurance Information**

*Required Info*                      *Primary Insurance*                                      *Secondary Insurance*  
Company Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State & Zip \_\_\_\_\_  
Telephone # \_\_\_\_\_  
Bills Mailed To \_\_\_\_\_  
Policy # \_\_\_\_\_  
Group # \_\_\_\_\_  
ID # \_\_\_\_\_

**Work Comp / Attorney Information**

*Required Info*                      *Workers Comp*                                      *Attorney*  
Employer/Atty \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State & Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

**Findings / Concerns**

*Symptoms / History / Exam*                                      *Clinical Concerns*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_