



# Teton Nuclear Medicine Service

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PLEASE READ CAREFULLY AND ANSWER EACH QUESTION IN FULL.  
IF YOU HAVE QUESTIONS PLEASE ASK THE RECEPTIONIST.

1. PATIENT'S NAME \_\_\_\_\_  
LAST FIRST MI AGE BIRTH DATE

Address \_\_\_\_\_  
STREET CITY STATE ZIP HOME PHONE #

Sex \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Social Security # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

2. RESPONSIBLE PARTY \_\_\_\_\_  
LAST FIRST MI RELATIONSHIP

Address \_\_\_\_\_  
STREET CITY STATE ZIP PHONE #

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

3. IN CASE OF EMERGENCY  
PERSON TO BE NOTIFIED \_\_\_\_\_  
NAME PHONE #

4. INSURED PERSON'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

5. REFERRING PHYSICIAN \_\_\_\_\_

## INSURANCE INFORMATION

### 1. PRIMARY INSURANCE

NAME OF INSURANCE COMPANY \_\_\_\_\_ INSURANCE ADDRESS (NUMBER, CITY, STATE, ZIP CODE) \_\_\_\_\_

ID# \_\_\_\_\_ POLICY /GROUP # \_\_\_\_\_ INSURANCE HOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

INSURANCE HOLDERS EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

### 2. SECONDARY INSURANCE

NAME OF INSURANCE COMPANY \_\_\_\_\_ INSURANCE ADDRESS (NUMBER, CITY, STATE, ZIP CODE) \_\_\_\_\_

ID# \_\_\_\_\_ POLICY /GROUP # \_\_\_\_\_ INSURANCE HOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

I consent to testing by Teton Nuclear Medicine Service LLC and to the release of this information to my physician. I agree to pay all fees and charges regardless of insurance coverage. I authorize the release of financial and medical information to my insurance company and I authorize them to pay any benefits directly to Teton Nuclear Medicine Service LLC. If collections on your account become necessary, a collection fee may be added to your account balance.

PATIENT'S SIGNATURE / GUARDIAN IF UNDER AGE 18 \_\_\_\_\_

DATE \_\_\_\_\_