Baylor Radiologists
Interventional Radiology
Patient Information

Date of Consultation:	**Referred By:**	
First Name:	**Last Name:**	
Last 4 Digits of SS#:	**Date of Birth:**	**Age:**
Home Phone:	**Cell Phone:**	
Work Phone:	**Email Address:**	
Address:		
City:	**State:**	**Zip:**
Diagnosis/Reason for Visit:		
Name of PCP or Gynecologist:		
Patient's Employer:	**Occupation:**	
Emergency Contact:	**Phone:**	
Primary Insurance Company:	**Policy No.**	
Address:		
City:	State:	Zip:
Telephone No.:	Group No.:	
Insured's Name:	Relationship to Patient:	
Employer:		
Secondary Insurance Company:	**Policy No.:**	
Address:		
City:	State:	Zip:
Telephone No:	Group No:	
Insured's Name:	Relationship to Patient:	
Employer:		

I authorize the release of all third party and insurance payments payable to Singleton Associates PA Baylor Radiologists and I accept full financial responsibility for this office visit and all future medical care not covered by my insurance company. Furthermore, I have been provided a copy of the HIPAA policies and procedures guidelines, and I hereby authorize Singleton Associates PA Baylor Radiologists to release medical and/or personal information to the hospital, other physicians and/or my insurance company as necessary for treatment and/or billing purposes.

_____
Patient's Signature

_____
Date