ORLANDO HEALTH® | Imaging Centers

LINE UP PATIENT I.D. LABEL HERE

NEW PATIENT FORM

ALTAMONTE / DOWNTOWN ORLANDO / SPRING LAKE / OCOEE / SANFORD

Please Print

Date: _____ Referring Physician: _____

Patient's Name: _____ SSN#: _____ - _____ - _____

Address: _____
City State Zip Code

Phone: _____
Home Phone Cell Phone Work Phone

Date of Birth: _____ Male _____ Female _____

Place of Employment: _____

Employer Address: _____

Employer Phone: _____

(Please Check)
Preferred Language: ❑ English ❑ Spanish ❑ Portuguese ❑ French ❑ Other

Race: ❑ Asian ❑ African American ❑ White ❑ American Indian ❑ Decline to state

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to State

Emergency Contact Name:_____

Emergency Contact Phone Number: _____Relationship to Patient:_____

IF THE PATIENT IS NOT SUBSCRIBER OF INSURANCE OR THE PATIENT IS A MINOR, PLEASE COMPLETE

Name of Insured or Parent/Guardian:

Address: _____
City State Zip Code

Phone: _____
Home Phone Cell Phone Work Phone

SSN#: _____ - _____ - _____ DOB: _____ Male _____ Female _____

Primary Insurance:

Insurance Carrier _____

Policy No. _____Group No. _____

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Secondary Insurance

Insurance Carrier _____
Name Address Phone Number

Policy No. _____Group No. _____

Is this a claim for:

Worker's Compensation? (circle one) YES NO Motor Vehicle Accident? (circle one) YES NO

AUTHORIZATION

I authorize Orlando Health Imaging Centers to perform procedures and treatment ordered by my physician and/or that may be medically necessary.

_____ MEDICARE: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release any information needed for this or any related Medicare claim to the Social Security Administration or its intermediaries or carriers. I permit a copy of this authorization to be used in place of the original request for payment of Medicare benefits.

_____ ALL OTHERS, I authorize any holder of medical or other information about me to release any information needed for this or a related claim. I permit a copy of this to be used in place of the original.

I assign and authorize payment of benefits to: OHRI, LLC (d/b/a Orlando Health Imaging Centers. Any services not covered by my insurance will become my responsibility for full payment of services rendered.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the supplied financial information.

_____ _____ _____
Patient (Parent/Guardian/Representative) Signature Date Time

Relationship to Patient: _____

Orlando Health Imaging Centers are owned and operated by OHRI, LLC, a Florida limited liability company.