ORLANDO HEALTH® | Imaging Centers

LINE UP PATIENT I.D. LABEL HERE

NEW PATIENT FORM

ALTAMONTE / DOWNTOWN ORLANDO / SPRING LAKE / OCOEE

Please Print

Date: ____________________ Referring Physician: ____________________

Patient's Name: ______________________________ SSN#: ______ - ______ -________

Address: ______________________________
City State Zip Code

Phone: ______________________________
Home Phone Cell Phone Work Phone

Communication Consent:
By providing my cell, land line or any other number(s), I expressly consent to receiving communications from the imaging center, its staff, its contractors, collection agents and others and any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s) or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services. If you wish to opt out, please contact Patient Access/Admitting Department personnel.

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:

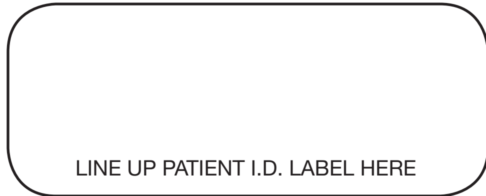
Insurance Carrier ______________________________

Policy No. ______________________________ Group No. ______________________________

ORLANDO HEALTH® | Imaging Centers

NEW PATIENT FORM

ALTAMONTE / DOWNTOWN ORLANDO / SPRING LAKE / OCOEE



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. Additionally I authorize payment of supplemental medical benefits to the physician or supplier for services. 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.

INTERPRETER ONLY	PATIENT ASSISTANCE PROVIDED
Interpreter Name: ____________ Agency & I.D.#: ____________ Team Member Name & I.D.#: ____________ ❑ Video Remote ❑ Tel ❑ In person Language: ____________	❑ Reader for Visually Impaired Name: ____________