EASTERN RADIOLOGICAL ASSOCIATES
2900 12th Ave North 2E
Billings, MT 59101

PATIENT INFORMATION SHEET

FIRST			M.I.	LAST	
ADDRESS			CITY	STATE	ZIP
HOME PHONE #	CELL PHONE #			ETHNICITY 1. LATINO OR HISPANIC 2. NOT LATINO OR HISPANIC	
CAN WE LEAVE A MESSAGE WITH PRIVATE INFORMATION?	YES	NO			
BIRTHDATE	AGE	SEX (CIRCLE) M F	MARITAL STATUS	RACE	SPOUSES NAME
PATIENT EMPLOYER/ OCCUPATION:			**WHOM MAY WE SPEAK WITH ABOUT YOUR CARE AND CONDITIONS?**		
ADDRESS			CITY	STATE	ZIP
EMERGENCY CONTACT				PHONE #	
PRIMARY INSURANCE COMPANY				PHONE	
ADDRESS		CITY		STATE	ZIP
INSURED'S NAME	ID #		GROUP #		BIRTHDATE
SECONDARY INSURANCE COMPANY				PHONE	
ADDRESS		CITY		STATE	ZIP
INSURED'S NAME	ID #		GROUP #		BIRTHDATE

INSURANCE INFORMATION- ***fill in blanks if you do not have your insurance cards with you***

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. Should collection proceedings or other legal action become necessary to collect an overdue account, you (the patient or the patient's responsible party) understand that ERA has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The undersigned agrees to pay for all costs and expenses including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

Signed: ____ **Date:**_______________