

Advanced Diagnostics, Inc.

1 Wellness Blvd. Suite 105 Irmo, SC 29063 - 115 Blarney Dr. Suite 105 Columbia, SC 29223
Office (803)419-4235 Fax (803)419-4236

PATIENT INFORMATION					
Last Name:		First Name:		Middle Initial:	
Date of Birth:	Age:	Social Security Number:		Sex:	
Mailing Address:		City, State:		Zip Code:	
Home Phone: ()		Work Phone: ()		Cell Phone: ()	
Referring Office:		Referring Physician:		Height:	Weight:

EMERGENCY CONTACT		
Name:	Phone#:	Relation to patient:

PRIMARY INSURANCE			
Name of Insurance Company:		ID Number:	Group Number (if applicable):
Name of Policy Holder:	Birthdate of Policy Holder:	SS# of Policy Holder:	Relation to Patient:

SECONDARY INSURANCE (if applicable)			
Name of Insurance Company		ID Number:	Group Number (if applicable):
Name of Policy Holder:	Birthdate of Policy Holder:	SS# of Policy Holder:	Relation to Patient:

Release of Information:

I hereby consent to Advanced Diagnostics, Inc's use and disclosure of any medical information concerning me that is necessary for my treatment and for Advanced Diagnostics, Inc. to secure payment for its services rendered to me, and for other healthcare business operations. Such uses and disclosures may include releasing information requested by my insurance company, other physician's offices, hospitals, workers compensation insurers and disability determination. I also consent to Advanced Diagnostics, Inc. obtaining medical information from other physician's offices and hospitals such as necessary to provide services to me. I acknowledge that Advanced Diagnostics, Inc. has provided me with a copy of the Notice of Privacy Practices.

Insurance Assignment:

I hereby assign to Advanced Diagnostics, Inc. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. I certify that all information provided here is correct to the best of my knowledge.

Signature of Patient or Responsible Party

Date