CORA
CENTRAL OREGON
RADIOLOGY ASSOCIATES

CMI CASCADE MEDICAL IMAGING

COMRI CENTRAL OREGON MAGNETIC RESONANCE IMAGING

CENTRAL OREGON RADIOLOGY ASSOC., P.C.
CASCADE MEDICAL IMAGING, LLC
CENTRAL OREGON MAGNETIC RESONANCE IMAGING, LLC

NEW PATIENT INFORMATION

(please print)

Patient Name:____ Date:__________________

Last (**Include Jr, Sr, MD etc**) First MI

Previous Name(s) and/or **Also Known As** Name(s)____

Phones : (_______)____________________ (_______)____________________ (_______)____________________

Home Cell Work

Mailing Address:______________________________ City:__________ State:__________ Zip:__________

Birth Date:____________________ Age_______ ☐ Male ☐ Female SS#:_________-_________-_________

Check One: ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed Employer:__________________________________

Ordering Physician:______________________________ Add'l Copy to Dr.______________________________

RESPONSIBLE PARTY IF DIFFERENT THAN ABOVE

Name:______________________________________ Relationship To Patient:______________________

Mailing Address:______________________________ City:__________ State:__________ Zip:__________

Birth Date:____________________ Age_______ ☐ Male ☐ Female SS#:_________-_________-_________

Check One: ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed Employer:__________________________________

Company Work Phone Number

INSURANCE INFORMATION

Check What Applies: ☐ Illness ☐ On The Job ☐ MVA ☐ Other Date of Injury:_________/_________/_________

If On The Job Injury - Employer on Injury Date or Employer Insurance is through:______________________

Primary Ins. Co.:__________________________ Secondary Ins. Co.:__________________________

Insured's Name:__________________________ Insured's Name:__________________________

DOB:______________ SS #_______/______/______ DOB:______________ SS #_______/______/______

Group#______________ ID #______________ Group#______________ ID #______________

AUTHORIZATION AND FINANCIAL AGREEMENT FOR DIAGNOSTIC RADIOLOGY SERVICES

I authorize treatment of the person named above and agree to pay all fees and charges. I understand I am financially responsible to CORA/COMRI/CMI for all charges for services regardless of insurance coverage. It is agreed that payments will not be delayed or withheld because of any insurance or the pendency of claims thereon. I agree to pay all charges for myself and my family shown by my statements. In the event legal action is necessary to collect an unpaid balance due for services rendered to myself or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines.

I hereby authorize CORA/COMRI/CMI to release any necessary medical information for my care and treatment.

X Signature of Patient or Guarantor:____ Date:__________________