LANDMARK IMAGING
MEDICAL GROUP INC

PATIENT REGISTRATION

Name Social Security # - -
Last *First* *Middle*
Address Birth Date: Cell phone ( ) Age

City St Zip Sex: M ☐ F ☐ Date of Injury

Phone ( ) - Referred by:

Accident? Yes ☐ No ☐ / Auto ☐ Work ☐ Other ☐ Employment Status: Employed ☐ Student ☐ (F/T-P/T)

Employer Occupation Work Phone ( ) -

Nearest Relative/Friend Not Living with You Phone ( ) -

Spouse Name Spouse Employed by: Phone ( ) -

Insurance Information

Medical Ins. Co. #1

Social Sec. #
Of Insured - - Policy# or Group# Relationship to patient

Insured's Name Authorization:

DOB of Insured Employer Insurance Name

Address City St Zip Phone ( ) -

Medical Ins. Co. #2

Social Sec. #
Of Insured - - Policy# or Group# Relationship to patient

Insured's Name Authorization:

DOB of Insured Employer Insurance Name

Address City St. Zip Phone ( ) -

Attorney? Yes ☐ No ☐ Attorney Name: Phone ( ) -

Auto/Work Comp Ins. (Name/Address)

Adjuster Name Phone ( ) -

I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING MEDICAL GROUP, INC** I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature _____ Date _____

11620 Wilshire Blvd., Suite 100 Los Angeles, CA 90025 Phone 310.914.7336 Fax 310.914.7326
www.landmarkimaging.com

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PLAIN FILM RADIOGRAPHY (X-RAY) PATIENT CLINICAL HISTORY

PATIENT NAME: _____DATE: _____

DATE OF BIRTH: _____

PROCEDURE_____

REFERRING PHYSICIAN: _____

ADDITIONAL COPY OF REPORT TO WHOM? _____

1. Chief complaints/Reason for exam? _____
2. How long have you had this problem?_____
3. Have you had any surgeries? ☐ YES ☐ NO

   If yes, describe surgeries and give dates._____

   _____

   _____
4. Have you had any radiology exams or other tests for this problem, or other problems?

   ☐ YES ☐ NO

   If yes, please list dates, tests, and results, if you know._____

   _____

   _____
5. Are you pregnant, or might you be? ☐ YES ☐ NO
6. Date of last menstrual period?_____

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