

**Insurance Info/Women Form**

Date of last menstrual period: \_\_\_\_\_

Is there a possibility that you are pregnant? Yes No

\*\* I understand that the examination I am having involves radiation and that radiation may cause injury to the unborn fetus, although the likelihood of such injury is slight. My physician feels that the information to be gained from the examination is important to my health, and I therefore wish to have X-Rays performed.

If you think you may be pregnant, please inform the Technologist prior to the examination.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Information**

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy/I.D. #: \_\_\_\_\_

Is patient covered by second insurance company? Yes No

2nd Insurance Company Name: \_\_\_\_\_

Do you have P.I.P. coverage? (If this is not related to an automobile accident skip to Primary Insured Info.) Yes No

Automobile Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Insured Information**

Are you the primary insured for your insurance? Yes No

If yes, please skip to next page. If no, please continue.

Primary Insured Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Primary Insured SS#: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_