Ocean Medical Imaging of Delaware

Milton Medical Park
611 Federal St, Suite 4
Milton, DE 19968

ACR American College of Radiology Accredited Facility

Patient Information

Last Name:	**First Name:** **M.I.:**		**Date of Birth:**
Mailing Address:		**City/State/Zip:**	
Home Phone:	**Cell Phone:**	**Employer:**	**Employer Phone:**
Social Security #:	**Sex:** [ ] Male [ ] Female	**Marital Status:**	**Primary Care Physician:**
Spouse Name:	**Date of Birth:**	**Spouse Phone:**	**Spouse SSN:**

Responsible Party – If Patient is a Minor or Student

Last Name:	**First Name:** **M.I.**		**Date of Birth:**
Relationship to Patient:	**Phone:**	**Social Security #:**	
Address (if different from above):		**City/State/Zip:**	

Additional Information (Please fill out all sections below)

Email address:	**Can we leave a message regarding your medical care?** [ ] **Yes** [ ] **No**	
Race (please select):	**Ethnicity** (please select):	**Preferred Language** (please select):
[ ] White [ ] American Indian	[ ] Hispanic or Latino	[ ] English
[ ] Hispanic [ ] Black or African American	[ ] Not Hispanic or Latino	[ ] Spanish
[ ] Asian [ ] Other _____	[ ] Decline	[ ] Other _____

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company:	**Insurance Company:**
Member ID #:	**Member ID #:**
Policy Holder:	**Policy Holder:**
Policy Holder Date of Birth:	**Policy Holder Date of Birth:**
Policy Holder Social Security #:	**Policy Holder Social Security #:**
Relationship to Patient:	**Relationship to Patient:**

Emergency Contact

Name:	**Phone:**	**Relationship:**

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits directly to OCEAN MEDICAL IMAGING OF DELAWARE for services rendered. I understand that I am responsible for all charges regardless of insurance coverage, co-pays, deductibles and co-insurances. I agree that I am responsible for any collection charges that may incur should my account be placed with a collection agency.

RELEASE OF MEDICAL INFORMATION: I hereby authorize the release of any medical information necessary to process this claim and for my course of treatment. Please release any requested films/CDs and reports necessary for my course of treatment.

CONSENT FOR TREATMENT: I consent to treatment by OCEAN MEDICAL IMAGING OF DELAWARE. I hereby grant permission to the physicians, employees, and other persons authorized by OCEAN MEDICAL IMAGING OF DELAWARE, to render routine medical care that includes diagnostic imaging to carry out all orders deemed necessary by my attending physician. I understand that no guarantee or assurance will be made as to the results that may be obtained.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby consent to the use and disclosure of my health information for treatment, payment and health care operations/purposes as described in OCEAN MEDICAL IMAGING OF DELAWARE'S Notice of Privacy Practices. I hereby acknowledge that I have received a copy of OCEAN MEDICAL IMAGING'S Notice of Privacy Practices.

Signature of Responsible Party: _____ Date: _____