

MCLEAN RADIOLOGY

Ian D. McLean, D.C., DACBR
Diplomate, American Chiropractic Board of Radiology

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Patient Information

Patient's Name: _____ Sex: _____ Age: _____

Referring Doctor: _____ UPIN: _____

Chief Complaint: _____

Previous Diagnosis, Surgery, Trauma, Cancer, Area Of Concern: _____

Date of Examination _____ Verbal Report () _____ FAX Report () _____

Bill doctor's office Bill Insurance Payment enclosed

Submit Insurance Card/Documentation Or Complete:

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone () _____ Date of Birth: ____/____/____ SS#: _____

Patient's Employer: _____ Work Phone () _____

Primary Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone () _____

Policy No: _____ Claim No: _____ Group/Plan _____

First Insured's Name _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Relationship: Spouse Child Other

Insured's Employer: _____

Related To Employment? Accident? Date: ____/____/____ State: _____

Attorney: _____

Address: _____ Phone () _____

Patient Consent

I understand that this office will have my radiographs interpreted by Ian D. McLean, D.C., D.A.C.B.R., a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and accordingly I hereby authorize Ian D. McLean, D.C., D.A.C.B.R. assignment of benefits for services rendered directly from my insurance carrier or attorney. Accordingly I authorize Ian D. McLean, D.C., D.A.C.B.R., p.c. to obtain information necessary to secure payment of benefits and authorize the use of this signature on associated benefit submissions. I also, authorize the release of any medical information necessary to process this claim. Any amounts owed but not collected within forty-five days of the service will be my responsibility.

This service is not covered by Medicare.

Patients/Guardian Signature: _____ Date: _____

Referring Doctors Name: _____