

**Singleton Associates, P.A.  
Interventional Radiology  
Patient Information Form**

<b>Date of Consultation:</b>		<b>Referred By:</b>	
<b>First Name:</b>		<b>Last Name:</b>	
<b>SS#:</b>	<b>Date of Birth:</b>	<b>Age:</b>	
<b>Home Phone:</b>		<b>Cell Phone:</b>	
<b>Work Phone:</b>		<b>Email Address:</b>	
<b>Address:</b>			
<b>City:</b>		<b>State:</b>	<b>Zip:</b>
<b>Diagnosis/Reason for Visit:</b>			
<b>Name of Gynecologist:</b>			
<b>Patient's Employer:</b>		<b>Occupation:</b>	
<b>Emergency Contact:</b>		<b>Phone:</b>	
<b>Primary Insurance Company:</b>		<b>Policy No.</b>	
Address:			
City:		State:	Zip:
Telephone No.:		Group No.:	
Insured's Name:		Relationship to Patient:	
Employer:			
<b>Secondary Insurance Company:</b>		<b>Policy No.:</b>	
Address:			
City:		State:	Zip:
Telephone No:		Group No:	
Insured's Name:		Relationship to Patient:	
Employer:			
<p>I authorize the release of all third party and insurance payments payable to Singleton Associates, P.A., and I accept full financial responsibility for this office visit and all future medical care not covered by my insurance company. Furthermore, I have been provided a copy of the HIPPA policies and procedures guidelines, and I hereby authorize Singleton Associates, P.A. to release medical and/or personal information to the hospital, other physicians and/or my insurance company as necessary for treatment and/or billing purposes.</p>			
<hr/> Patient's Signature			
<hr/> Date			