8620 Wicker Ave.
Suite A
St. John, IN 46373

219.365.4393
Fax: 866.382.2213

PREMIERE ULTRASOUND
3D & 2D DIAGNOSTICS

Date: _____

CPT Code: _____

Diagnosis Code: _____

DIAGNOSTIC ULTRASOUND REGISTRATION FORM

Patient Information:

Full Name: _____
First Middle Last

Date of Birth: _____ Social Security Number: _____/_____/_____

Spouse/Partner's Name: _____
First Middle Last

Address: _____ City: _____ St:____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____

Employer Name: _____ Employer Phone: _____

Emergency Contact: _____ Phone: _____

History:

Referring Physician's Name: _____

You are here for: _____

Problems you are currently having?_____

Have you followed pre-exam instructions? _____

Prescription Here:

PREMIERE ULTRASOUND
3D & 2D DIAGNOSTICS

Primary Insurance Information:

Insurance Company Name: _____

Phone Number: _____

Policy Number: _____ Group Number: _____

SUBSCRIBER INFORMATION

Full Name: _____
First Middle Last

Date of Birth: _____ Social Security Number: _____/_____/_____

Address: _____ City: _____ St:____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Employer Name: _____ Employer Phone: _____

Sex: Male ☐ Female ☐ Relationship to Patient: _____

Secondary Insurance Information:

Insurance Company Name: _____

Phone Number: _____

Policy Number: _____ Group Number: _____

SUBSCRIBER INFORMATION

Full Name: _____
First Middle Last

Date of Birth: _____ Social Security Number: _____/_____/_____

Address: _____ City: _____ St:____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Employer Name: _____ Employer Phone: _____

Sex: Male ☐ Female ☐ Relationship to Patient: _____

I verify the accuracy of the information above. I authorize Premiere UltraSound, who has treated me, or my dependent to furnish any medical information requested. In consideration of the services rendered, I transfer and assign any benefits of insurance to Premiere UltraSound if they are credentialed with my insurance company. If Premiere UltraSound is not credentialed with my insurance or if my insurance will not cover another ultrasound, I understand that I am financially responsible for the charges related to this ultrasound session. I understand that I am financially responsible for any co-pay and/or deductible amounts. I understand that I am responsible for payment of my account balance if my health plan does not reimburse (or only partially reimburses) my medical services. I also understand that by signing this form I am consenting to the treatment for which I about to undergo.

Patient Signature: _____ Date: _____