

Accident Details

Patient's Name: _____

Are these symptoms related to an accident? **Y** **N** **Date of injury** _____

If yes, was the accident at... Work Auto Home Other

If yes, please give a description of the incident:

Medical Records Consent: I authorize Gulf Coast MRI & Diagnostic to release any medical records to my physicians, third party payors, including but not limited to insurance companies, workers' compensation, and other parties.

Assignment of Benefits: I authorize an irrevocable assignment of benefits, to be paid directly to Gulf Coast MRI & Diagnostic under said insurance policies including major medical by reason of services rendered therein. I understand that I am financially responsible for all charges whether or not paid by my insurance. A photographic copy of this authorization will serve the same purpose as the original.

Primary Insurance _____	<i>If no secondary insurance, please write N/A.</i> Secondary Insurance _____
ID# _____ Group# _____	ID# _____ Group# _____
Relationship to Patient _____	Relationship to Patient _____
Insured Date of Birth _____	Insured Date of Birth _____

Patient's Signature: _____ **Date:** ____/____/____

Parent or Guardian's Signature: _____ **Date:** ____/____/____
(If patient is a minor)

Parent or Guardian Phone Number _____