RapidSound, Inc / Green Valley Imaging
450 W Continental Rd
Green Valley, AZ 85622
520.625.7670

NEW PATIENT QUESTIONNAIRE

Full Name: _____ Social Security Number: _____
Nombre completo *No de saguro social*

Date of Birth: _____/_____/_____ Age: _____ Sex: Male _____ Female _____
Fecha de nacimiento *Edad* *Masculino* *Feminino*

Marital Status: S M W D Email Address: _____
Estado civil *Direccion de email*

Home Phone: _____ Mobile Phone: _____
Telefono de casa *Telefono de cellular*

Home Address: _____ Preferred Language: _____ English _____ Spanish
Direccion

City: _____ State: _____ Zip Code: _____
Ciudad *Estado* *Codigo postal*

Mailing Address (if different)_____Apt/Space: _____
Direccion *Numero*

City: _____ State: _____ Zip Code: _____
Ciudad *Estado* *Codigo postal*

Employer: _____ Work Phone: _____
Patron *Telefono de trabajo*

Emergency Contact: _____
Pariente/Amigo a caso en emergencia

Phone number: _____ Relationship to patient: _____
Telefono *Relacion al paciente*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS, PAYMENT OF ACCOUNT

I authorize RapidSound, Inc. to release medical information for insurance purposes concerning treatment of the above named patient while under their care. I authorize payment of any insurance benefits for medical or surgical services directly to RapidSound, Inc. I agree to pay fees not covered by insurance benefits directly to RapidSound, Inc. If collection proceedings are required, I agree to pay all reasonable collection fees.

If payment is not received within thirty (30) days, a 15% interest rate per year shall apply. We also reserve the right to charge a $25.00 collection fee, plus court costs and other associated fees.

Signature / Firma: _____ Date / Fecha: _____