TEMPLETON IMAGING, Inc.

Selma Carlson Diagnostic Center

Exam Date:	Exam Time:	MRN:

CPT, Exam Description

Accession #:

ICD-10:

☐ PRIORS REQUESTED_____ ☐ LABS _____ ☐ TASKLIST Rx

Last Name	First Name	MI	Date of Birth	Sex

Address	City	State	Zip Code

Home Phone#	Work #	Cell#	Patient's Email

Patient's Employer	Employer Address	City	State	Zip Code

Emergency Contact	Relation to patient	Emergency Contact Phone#

Referring Physician	Referring Physician Phone #	Ref Physician Fax #

Ref Physician Address	City	State	Zip Code

CC Physician:	CC Physician:

Responsible Party (please write "same as above", if applicable)

Last Name	First Name	MI	Date of Birth	Sex

Address	City	State	Zip Code

Relation to patient	Phone#	Email	Employer

Insurance / Payer Self-Pay ☐ Insurance ☐ Direct Bill ☐

Insurance / Payer	Policy Number	Group Number

Subscriber First Name	Subscriber Last Name	Date of Birth	Relation to patient

Is there any possibility you are pregnant? **YES** **NO** **Patient's initials: _____**

Are you currently involved in a clinical trial study? **YES** **NO** **Patient's initials: _____**

I agree that all of the above information is true and correct.

Signature: _____

Parent/Legal Guardian Signature: _____

For Office Use Only:

Patient Name, Date of Birth, Exam & Physician have been verified.

Front Office: _____

Tech(s): _____

For Blue Shield members only: Blue Shield members will receive **two bills** in the mail for their exams. You will receive one bill from the Imaging Facility for the procedure, and one bill from 'Bay Medical Imaging' for the reading fee.
This process is required by Blue Shield Insurance and **NOT** the Imaging Facility.