DIAGNOSTIC X-RAY CONSULTATION SERVICES®

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Patient's Name: _____ Date of Birth: _____

Referred by Dr: _____ Dr.'s Phone: _____ Height: _____ Weight: _____

Date Taken: _____ ☐ Male ☐ Female

S.S.#: _____

DO NOT WRITE IN THIS SPACE
Date of Report:

Patient's Complaint - PAIN (Where? When? What Relieves? etc.):

Patient's History - (Recent: Trauma, Surgery, Disease, Weight Gain/Loss? History of Cancer? Irradiation Therapy?):

Specific Information Desired - (Please check or circle any areas in question):

Treating Diagnosis (ICD-10 Code):

Patient's Name & Address:

Patient's Telephone #'s:

Relationship to Insured:
☐ Self ☐ Spouse ☐ Child
☐ Other _____

Was Condition Related To:
☐ Employment ☐ Auto Accident
☐ Other _____

Date of Injury:

Insurance Company Name, Address & Telephone:

☐ Group	☐ W/C	☐ Med Pay	☐ 3rd Party	☐ Uninsured / Under Insured

Insured's Name:

Insured's Claim/Group #:

Insured's Policy/USER ID#:

Attorney's Name, Address & Telephone #: