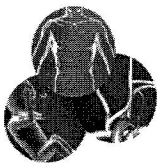

SONOVIEW IMAGING LTD.
ULTRASOUND CENTER

PATIENT INFORMATION ***** PLEASE PRINT CLEARLY*****

Last Name _____ First _____ Middle _____

Please tick: **Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Gender** ☐ Male ☐ Female

Mailing Address _____

_____

Parish _____ Zip Code _____
Telephone Home _____ Work _____ Cellular _____

Date of Birth _____/_____/_____ Email _____
Month Day Year
Employer _____
Address _____

Emergency Contact Person _____ Relationship _____
Telephone Home _____ Work _____ Cellular _____

POLICY HOLDER (**If** different from above)

Relation to above Patient: (*Please Tick*) ☐ Parent ☐ Self ☐ Spouse ☐ Other*(specify)* _____
Last Name _____ First _____ Middle _____
Mailing Address _____

_____

Parish _____ Zip Code _____
Telephone Home _____ Work _____ Cellular _____ Fax _____
Date of Birth _____/_____/_____
Month Day Year
Employer _____
Address _____

INSURANCE INFORMATION

☐Argus/Somers Isles ☐ BFM ☐ Colonial ☐ GEHI ☐ Kitson Benefit Services
☐ Freisenbruch-Meyer ☐ British American ☐ HIP ☐ Cash ***EFFECTIVE DATE*** _____

Group # _____ Certificate # _____

I, the undersigned, hereby authorize payment of Insurance Benefits to Sonoview Imaging for services rendered to the patient named on this form, together with the release of any medical information necessary to process a medical claim.

I understand that I am solely responsible for full payment of all costs incurred in the event that my insurance company does not pay, as well as all legal costs, agency charges (33 1/3%), interest (7%),and other expenses that may be charged for collection of outstanding accounts.

Signature _____ **Dated** _____

MEMBER OF BERMUDA DEBT COLLECTION AGENCY LIMITED