X-Ray order: 1.800.933.2672
Phone: 408.799.6103
Fax: 408.904.7406

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____

DATE OF BIRTH:_____ ☐ FEMALE ☐ MALE

ADDRESS:_____

CITY:_____ PHONE NUMBER:_____

EXAM INFORMATION

1._____ No. View_____ 4._____ No. View_____

2._____ No. View_____ 5._____ No. View_____

3._____ No. View_____ 6._____ No. View_____

Symptoms:_____

Reason portable x-ray necessary (circle one):

Bedridden *Confused* *Combative* *Possible FX* *Too ill* *Other:*_____

PHYSICIAN INFORMATION

PHYSICIAN:_____ **NPI**:_____

ADDRESS:_____ PHONE:_____

CITY:_____ ZIP:_____ *SIGNED ORDER (MD/DO/NP) REQUIRED*

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE:_____ ID #:_____

SECONDARY INSURANCE:_____ ID #:_____

BILLING CONTACT EMAIL:_____

FACILITY INFORMATION (IF APPLICABLE)

FACILITY:_____ PHONE:_____

FACILITY TYPE (circle one):

SNF - ASSISTED LIVING - SURGERY CENTER - BOARD & CARE - HOME - OTHER:_____

ADDRESS:_____ ROOM #:_____

CITY:_____ STATE:_____ ZIP:_____