Tampa Bay Mobile Mammography 813-601-1925
Info@TampaBayMobileMammography.com
Patient Registration Form
This form must be competed in full before exam

Appointment Date: _____ Appointment Time_____

Patient Name: _____

Mailing Address: _____ Apt _____

City: _____ State: _____ Zip: _____

Phone:(____) - _____-_____ Date of Birth_____/_____/_____

Insurance Information

Insurance Company: _____

Member ID: _____

Group Number: _____

Relationship to Policy Holder: _____

Note: You must have a current Physician that we can send your report to.
You must complete the following:

Physicians Full Name: _____

Street: _____ Suite: _____

City: _____ State: _____ Zip: _____

Phone:(____) - _____-_____ Fax:(____) - _____-_____

Authorization To Pay: I hereby authorize payment directly to the business office of Direct Medical Imaging, LLC, at 8824 Skymaster Drive, New Port Richey, FL 34654 for medical benefits, if any, otherwise payable for service. I understand that I am financially responsible for charges not covered by my insurance.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I have read and understand this Office's Notice of Privacy Practices displayed on the Coach. I understand that I may have a printed copy if requested.

_____

Print Name

_____

Signature

_____

Date

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Authorization to Release Previous Breast Imaging Records To Direct Medical Imaging, LLC

Patient Name:_____ Date of Birth_____

Phone Number:_____

I hereby authorize_____(prior imaging facility where I had my last mammogram) to release my records to Direct Medical Imaging, LLC.
These images and/or reports will be used to compare with my present examination

If not local please indicate facility name, city, state and phone number

_____

___Mammogram Images & Reports ___Breast Ultrasound & Reports ___Breast MRI & Reports

To:
Direct Medical Imaging
PO Box 5468
Lakeland, FL 33807-5468
813-436-8437 FAX
813-601-1925 Office

Please send reports with images

___I understand I may revoke this authorization at any time by notifying the above referenced person/physician organization in writing

___I understand the revocation does not apply to information that has already been released in response to this authorization. Unless revoked, this authorization will expire (12) months from the date of this authorization.

___I understand that the information in my medical record may include information about my medical history, diagnoses, and/or treatment.

Patient Signature:_____ Date_____

Printed Name:_____