Montgomery Imaging Center

2055 Normandie Dr. Suite 108
Montgomery, AL 36116
334.288.4624

PATIENT INFORMATION

PATIENT NAME:	**DOB:**	**SEX:** M F	**RACE:**	**SSN:**
PATIENT ADDRESS:	**HOME PHONE:**			
CITY/STATE/ZIP:	**WORK PHONE:**			
EMPLOYER:	**EMPLOYER ADDRESS:**			
REFERRING PHYSICIAN:				
IS THIS VISIT RELATED TO AN ACCIDENT/INJURY? YES NO **IF YES, DATE OF ACCIDENT/INJURY:**	**PLACE OF ACCIDENT/INJURY: (CIRCLE ONE)** **WORK AUTO HOME OTHER** **If Auto, list State accident occurred:**			
EMERGENCY CONTACT NAME AND RELATIONSHIP:	**ADDRESS:**		**PHONE:**	

PLEASE PROVIDE THIS INFORMATION ONLY IF YOU DO NOT HAVE YOUR INS CARD AVAILABLE

GUARANTOR NAME:	**DOB:**	**SEX:** M F	**RACE:**	**SSN:**
GUARANTOR ADDRESS:	**HOME PHONE:**			
CITY/STATE/ZIP:	**WORK PHONE:**			
EMPLOYER:	**EMPLOYER ADDRESS:**			

PAIN ASSESSMENT

Are you experiencing any pain today? (circle one) **YES** **NO**

If YES, please rate your level of pain on the scale below.

1 2 3 4 5 6 7 8 9 10
Mild **Severe**