National PET Scan
DADE, LLC
7867 North Kendall Drive – Suite 121
Telephone: 305-455-3000

Patient Information

SSN _____ DOB _____ SEX _____ TITLE (MR, MS, etc.) _____

LAST NAME _____ FIRST NAME _____ MID NAME _____ SUFFIX _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE _____ WORK PHONE _____

EMERGENCY _____ RELATIONSHIP _____ PHONE _____

ETHNIC ORIGIN (OPTIONAL) _____ RELIGION (OPTIONAL) _____

MARITAL STATUS EMPLOYER _____ PHONE _____

Medical Information

HEIGHT _____ (in) WEIGHT _____ (lbs) DIABETIC? _____

IS THERE A CHANCE THAT YOU ARE PREGNANT? _____ DO YOU HAVE A PACEMAKER? _____

CURRENT SYMPTOMS / REASON FOR PROCEDURE _____

Insurance Information

Auth

	PRIMARY	SECONDARY	TERTIARY
NAME			
ADDRESS			
PHONE			
MEMBER ID #			
GROUP #			
INSURED NAME			
RELATIONSHIP			
INSURED SSN			
INSURED DOB			

Insured's Employer

COMPANY _____ CONTACT PERSON _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

Referring Physician

FIRST NAME _____ LAST NAME _____ SUFFIX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

SPECIALTY _____ UPIN # _____ FAX _____

Primary Care Physician

FIRST NAME _____ LAST NAME _____ SUFFIX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

SPECIALTY _____ FAX _____