REQUEST FOR COPIES OF X-RAYS, CT SCANS, MRI'S AND SONOGRAMS

PATIENT MUST GIVE A 48 HOUR NOTICE ON REQUEST FOR X-RAY FILMS.
PATIENTS MAY BE RESPONSIBLE FOR A 3.00 CHARGE PER FILM.

Today's Date: ______________________

Patient Name: ____

D.O.B.:___________________

Phone # :__________________________(so we may call when films are ready)

Date film was done: _________________ **Name of Medical Insurance:** ________________

I NEED COPY/COPIES OF: (Please be specific with details, when requesting films)

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REASON FOR COPIES OF X-RAYS: (If for another Physicians office, please give physicians name)

____

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Date Film was picked up: ________________

Amount Due: $_______________ **Initial:** _________

111 Maltese Drive, Middletown, NY 10940 · Phone (845)342-4774 · Fax (845) 343-6116
Visit us on the web www.middletownmedical.com

Patient Signature: ____

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