ORDERED BY: ____ PHONE: ______________ FAX:____________

Performed By: Carey Gentry

Main Phone: 626.595.0657
X-Ray Tech: 626.595.0653
E-Fax1: 626.576.9500
E-Fax2: 877.660.0365

PORTABLE SERVICE REQUISITION

PATIENT NAME:		GENDER:
DATE OF BIRTH		ROOM #:
HOME PATIENT:		

SERVICE DATE: __________________ PRIORITY: _____________ ENTERED BY: ______________________

PROCEDURE(S): ____

REASON(S): ____

ORDERING PHYSICIAN: ____ NPI: ________________________

*Please attached doctor's orders,and copy of patient's insurance

INSURANCE TYPE	PAYER NAME	HIC/SUBSCRIBER	POLICY#/GROUP	PLAN

PRIMARY:
(ie. Medicare/PPO) _________________ __________________ _________________ _________________

SECONDARY:
(ie. supplement) _________________ __________________ _________________ _________________

MED A: Y / N/ NA **HOSPICE**: Y / N / NA

RESPONSIBLE PARTY:	ADDRESS:	PHONE:
____________________	_______________________________________	____________________

GENTRY IMAGING INC,
333 E. Rainbow Drive, Azusa, CA 91702