# LOGAN UNIVERSITY
## CHIROPRACTIC HEALTH CENTERS

## *DEPARTMENT OF RADIOLOGY IMAGING INTERPRETATION REQUEST*

### PATIENT INFORMATION

**Patient Name** _____ **Date of Birth**_____
**Patient Address**_____
_____ **Gender** □ **Female**
**Patient Telephone**_____**Cell**_____ □ **Male**

**Name of Insured** _____ **Insured's Date of Birth**
**Insurance Carrier**_____ _____
**Insurance ID**_____ **Group #** _____
**Insurance Address** _____
**Insurance Telephone**_____ **SSN** _____

### PATIENT' S HISTORY

**Patient's Chief Complaint** _____
**Trauma** _____
**Surgeries** _____
**History of Cancer?** □ Yes □ No _____
**Diagnosis**_____

### IMAGES SUBMITTED

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### REFERRING DOCTOR INFORMATION

**Referring Doctor**_____
**Referring Doctor's Address**_____ **Suite** _____
**City, State, Zip** _____ **e-mail** _____
**Telephone** _____ **Fax** _____
**Billing** □ **Bill Patient** □ **Bill Referring Doctor** **License Number** _____
**NPI** _____

**Doctor's**
**Signature**_____ **Date**_____

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**Revised January 1, 2014**