MIDDLETOWN MEDICAL
Your health care… all in one place!

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)

_____

_____

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

_____

_____

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

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Patient Signature: _____

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