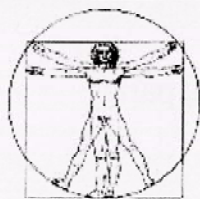


# DIAGNOSTIC OUTPATIENT IMAGING

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Office: (915) 881-1900  
Fax: (915) 771-9345

Date: \_\_\_\_\_

## Patient Information

Last Name \_\_\_\_\_ M.I. \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex \_\_\_\_\_

Patient Status  Single  Married  Other  Employed  Student

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Allergic To \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_