

X-RAY 505

X-RAY, GENERAL ULTRASOUND

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Mammography / Radiography / Ultrasound

Appointment Time _____ Date _____

Patient's Name: _____

Date of Birth: _____

Care Card Number: _____

Address: _____

Phone Number: _____

Examination/History:

Referring Doctor: _____ Billing #: _____

PLEASE INDICATE FOR BILLING:

MSP

ICBC

WCB

OTHER

CLAIM # _____