THE RADIOLOGY CLINIC

PATIENT INFORMATION

Patient Name: ____
First Middle Last

Address: ____
Street / City State / Zip

Date of Birth: __________ **Home Phone:** ______________ **Cell Phone:** ______________

Referring Physician: ______________________ **Email:** ______________________

Gender: ________ **SSN:** __________ How did you hear about us? ______________

Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Hawaiian Native or Pacific Islander □ White (Caucasian) □ Other □ Decline to state

Language: □ English □ Spanish □ Other, please specify: ______________________

PRIMARY INSURANCE INFORMATION

Insurance Name: ______________ Policy #: ______________ Group#: __________
Policy Holder: ______________________ Relationship to Patient: ______________
Employer: ______________________ Date of Birth: ______________
Address: ____
Street / City State / Zip

Authorization: ______________________

SECONDARY INSURANCE INFORMATION

Insurance Name: ______________ Policy #: ______________ Group#: __________
Policy Holder: ______________________ Relationship to Patient: ______________
Employer: ______________________ Date of Birth: ______________
Address: ____
Street / City State / Zip

HIPAA Release of Private Health Information

I hereby authorize the release of any private health information (PHI) obtained in the course of my registration, examination, and treatment, necessary to file or appeal any claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statute, or regulation. I acknowledge that if I wish to have any individual or entity restricted from access to my PHI, I will notify the office in writing. I acknowledge I have read the HIPAA Notice of Privacy Practices. **Would you like a copy of the Notice of Privacy Practices? □ Yes □ No**

Patient/Guardian Signature: ______________________________ Date: __________

Payment of Benefits & Medical Release Authorization

I authorize release of my medical records to my physician. I authorize payment of benefits, as determined by the company. I may still be responsible of any amount not paid by my insurance company in the event that the payments are made are not reasonable and customary. I authorize my health care provider, insurance company, organization, employer, or hospital to release any information requested with regard to my medical records or processing of my claim. I attest that the above information is correct to the best of my knowledge. If at any time I have a balance due which is more than 90 days old, I understand that my account may be referred to an outside collection agency without notice. If my account is sent to a collection agency, I hereby agree to pay for all collection costs incurred while collecting my unpaid debt in addition to finance charges at 25%. I have read and understand the contents of this form and I have had an opportunity to ask questions regarding the information on this form.

Patient/Guardian Signature: ______________________________ Date: __________

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Patient Name: ________________________ Weight: __________ Height: __________

Referring Physician: ____

Smoking Status: ☐ Daily ☐ Occasionally ☐ Former ☐ Never

Injury related? ☐ No ☐Yes, please specify ________________________________

____

Please state the reason for your procedure(s) today. What are your symptoms? ***VERY IMPORTANT***

____________ ____
Date Started

Pertinent medical history ____

List previous surgeries and approximate date: ________________________________

____

Latex Allergy: ☐ No ☐ Yes

List current medication(s): ☐ None ________________________________

Medication Allergies: ☐ None ☐ Yes, please specify ________________________________

____

Personal history of cancer? ☐ No ☐ Yes, please specify what type and when? ________________

____

FEMALE PATIENTS ONLY – PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you pregnant or any chance you may be: ☐ Yes ☐ No ☐ Unsure
2. Date of the start of your last period: ____________________
3. Are you on any type of Birth Control? ☐ Yes ☐ No
4. Are you breastfeeding? ☐ Yes ☐ No

Besides my physicians, I wish to disclose my protected health information with the persons listed below:

________________________________ ________________________________
Name Relationship