PATIENT INFORMATION

THE RADIOLOGY CLINIC

Patient Name: ______________________________ ID: ______________
First Middle Last
Address: ____
Street / City State / Zip
Date of Birth: ________ Home Phone: ____________ Cell Phone: ____________

Referring Physician: ________________ Email: ____________________

Gender: [sex]______ SSN: ____________ How did you hear about us: ____________
Ethnicity: Are you Hispanic? □ Yes □ No □ Decline to state
Race: □ White □ Black or African American □ Asian □ Other □ Decline to state
Primary Language: □ English □ Spanish □ Other

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
Authorization: ____________________

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. 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: __________

PATIENT INFORMATION

THE RADIOLOGY CLINIC

Patient Name: ______________________________ ID: ______________

Referring Physician: ______________________________

Smoking Status: □ Daily □ Occasionally □ Former □ Never

Do you have an aneurysm clip or a pacemaker?	□ Yes	□ No
Do you have a hearing aid or implant?	□ Yes	□ No
Do you have any metal in your body?	□ Yes	□ No

Weight: ____________ Height: ______________

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: ______________________________

____

List current medication(s): □ None ______________________________

Latex Allergy: □ YES □ NO Medication Allergies: □ None ______________________________

Personal history of cancer? □ YES □ NO If yes, what type and when? ______________________________

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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