Center for Diagnostic Imaging

Name: ________________________________ Sex: M / F Age:_____ Date: ________________

Street: ________________________________ Apart./PO BOX__________________________

City: ________________________________ State: ________ Zip Code: __________________

Home Phone: ______________________________ Work phone: ____________________________

Social Security #: ____________________________ Date of Birth: ____________________________
(Parent or Guardian SS# if minor patient)

Employer: ________________________________ Spouse/Guardian: __________________________

Emergency Phone: ____________________________ Marital Status: ☐ Single ☐ Married ☐ Other

Primary Physician:____________________________ Referring Physician: ________________________

PLEASE LIST ALL KNOWN ALLERGIES. ____

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INSURANCE INFORMATION

Primary

Ins. Company: ____________________________ Policy: __________________ Group: ______________

Subscriber Name: ________________________________ Date of Birth: __________________________

Social Security #:____________________________ Employer: ________________________________

Relationship to patient: ____________________________ Effective Date: __________________________

Secondary

Ins. Company: ____________________________ Policy: __________________ Group: ______________

Subscriber Name: ________________________________ Date of Birth: __________________________

Social Security #:____________________________ Employer: ________________________________

Relationship to patient: ____________________________ Effective Date: __________________________

Workman's Compensation

Insurance Company: ____________________________________ Policy/Claim:______________________

Date of Accident:______________________ Employer: ____

Automobile Accident

Insurance Company: ____________________________________ Policy/Claim:______________________

Date of Accident:____________________________________Insured Name: __________________________

ADVANCED DIRECTIVES

Advance Directives are documents written by patients to give instructions about their future medical care. Advance Directives state a person's choices about medical treatment or name someone else who can make those decisions if the patient becomes unable to.

1. Do you have an Advance Directive? (Living Will) ☐ **Yes** ☐ **No**

2. Would you like information about Advance Directive? ☐ **Yes** ☐ **No**

3. What influenced you to choose our facility for your Radiology needs?

Doctor referral ☐ Advertising ☐ Friend or Family ☐ Other ☐ ___________________

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1. I hereby authorize direct payment of medical benefits to Center for Diagnostic Imaging for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

2. I hereby authorize Center for Diagnostic Imaging to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

3. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request and that payment of authorized benefits be made on my behalf.

4. A photocopy of these assignments shall be valid as the original.

5. I have received a copy of my patient rights.

6. I understand my patient rights.

7. I have read and understood this facility's Notice of Privacy Practices.

8. I hereby authorize Center for Diagnostic Imaging to release my Protected Health Information (PHI) to the following individual(s):

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I understand this authorization will remain in effect until I request, in writing, to cancel this authorization.

PATIENT SIGNATURE: ____

PATIENT/ GUARDIAN IF PATIENT IS UNDER 18:____________________________________