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 and/or receive 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):

1. ____________________________________ **3.** ____________________________________

2. ____________________________________ **4.** ____________________________________

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:____