

(Please Print)



Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Is the patients place of residence a Skilled Nursing Facility? Yes No

Home Phone:() _____ Alternate Phone: () _____ Birthdate: _____

(Do Not Use Home Phone)

Emergency Phone Number: _____ Emergency Contact: _____

(Do Not Use Home Phone)

Name/Relationship to patient

Name of **Doctor Ordering Exam**: _____ Office Location: _____

Name of **Primary Care Physician**: _____ Office Location: _____

Employer's Name: _____ Employers Ph: _____

Social Security: _____ - _____ - _____ Male Female Single Married

(optional)

E-Mail: _____

Do you currently smoke? No Yes

Have you ever smoked? No Yes If yes: How many years? _____ Packs per day _____

Do you have any allergies (including Latex) ? _____

Do you have any medical disabilities? _____

FEMALE PATIENTS

Is there any possibility that you may be pregnant?

YES

NO

DON'T KNOW

Signature: _____ **Date:** _____

INJURY/ACCIDENT/LIABILITY INFORMATION

Is your service today related to an injury or accident? Yes No

Date of injury: _____ Location of injury/accident: _____

AUTO ACCIDENT RELATED:

Is this service Auto related? Yes No If yes-Auto insurance Claim # _____

Auto Insurance Name: _____ Agent Name/Phone # _____

WORK INJURY/ILLNESS RELATED:

If this service is related to a work accident or injury-Name of employer: _____

Workers Compensation Insurance: _____ Claim# _____

Phone number to verify workers compensation: () _____

If any other party is responsible for payment of services provided by Regional Medical Imaging, please provide name and phone number to contact that party below:

(Please Print)



INSURANCE INFORMATION

Primary Insurance Name: _____

Subscribers Name: _____ Date of Birth: _____

Patients Relationship to Subscriber: _____

Secondary Insurance Name: _____

Subscribers Name: _____ Date of Birth: _____

Patients Relationship to Subscriber: _____

Additional Insurance or Liable Party

Information: _____

Subscribers Name: _____ Date of Birth: _____

Patients Relationship to Subscriber: _____

MEDICARE QUESTIONS

Is the Cardholder Still Working? Yes No

If Yes - Name of Employer: _____

The Employer Has: 20 or more employees 19 or less employees

Are you retired? Yes No If Yes-Retirement Date: _____

Is the Cardholder's Spouse Still Working? Yes No

If Yes - Name of Employer: _____

The Employer Has: 20 or more employees 19 or less employees

Are you retired? Yes No If Yes-Retirement Date: _____

I certify that all information I have provided to Regional Medical Imaging is complete and accurate.

I request payment of authorized insured benefits to be made to Regional Medical Imaging for any services furnished to me. I understand that I am financially responsible for any and all services not covered or denied by insurance.

I authorize Regional Medical Imaging to release any medical information about me to my insurance company or responsible party, if injury related, that may be needed to determine benefits.

I acknowledge that it may be necessary to compare studies with other test results from other outside locations and authorize the release of any pertinent medical information to Regional Medical Imaging.

I consent for the procedure(s) to be performed. I have read, understand and consent to the authorization and assignment stated above.

Patient Name: _____ Patient Date of Birth: _____

Please print

Signature: _____ Date: _____

(If the patient is a minor (under 18), must be signed by parent or guardian.)

RMI Staff Signature: _____