



Date: _____

PATIENT INFORMATION: Legal Name: _____
Last First Middle

SSN: _____ Birth Date: _____ Male/Female _____ Marital Status: _____

Mailing Address: _____ Apt # _____ City: _____ State: _____ Zip _____

Home Phone (_____) _____ Cell Phone: (_____) _____

Employer _____ Work Phone: (_____) _____ Ext: _____

Employer Address: _____ City _____ State _____ Zip _____

Legal Guardian Name: _____ Birth Date: _____ Phone: (_____) _____

Guarantor's Name: _____ SSN: _____ Phone: (_____) _____

Referring Physician: _____ Phone: (_____) _____

Work Comp: Yes / No **Auto Accident:** Yes / No **Other Accident:** Yes / No

Claim Number: _____ Employer: _____

Date of Injury of Accident _____ Explanation: _____

INSURANCE INFORMATION: Relationship to Policy Holder Self /Spouse /Child / Legal Guardian /Other

COPY OF INSURANCE CARD ATTACHED Yes No **If card(s) are attached please proceed to next page.**

PRIMARY INSURANCE INFORMATION

Insurance Co Name: _____ Insurance Co Phone: (_____) _____

Insurance Co Address: _____ City _____ State _____ Zip _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ SSN: _____ DOB: _____ Male/Female _____

Policy Holder's Address: _____ Policy Holder's Phone: (_____) _____

Policy Holder's Employer: _____

SECONDARY INSURANCE: Insurance Co Name: _____

Insurance Co Address: _____ Phone: (_____) _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ SSN: _____ DOB: _____ Male/Female _____



Patient Consent and Authorization

By signing this form, you are granting consent to Diversified Radiology to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Your signature also authorizes Diversified Radiology to obtain information, including radiographs, from your physicians, any medical facilities, or other source for follow- up purposes. You also agree that you will be responsible for all non-covered services because of a lack of authorization or any other reason for denial.

Signature: _____ **Date:** _____

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information. You agree that you have read our Notice of Privacy Practiced and understand your rights and how your medical information may be used and disclosed and how you may obtain access to your health information. You have the right to request restrictions of how we disclose your health information. If you have additional questions or you have lost your Notice of Privacy Practices, you may visit your web site at divrad.com to obtain another copy.

Signature: _____ **Date:** _____

I authorize payment of medical benefits to treating physicians for these services and all future services. I authorize the release of any medical information necessary to process this and all future claims.

Signature: _____ **Date:** _____