LOGAN HEALTH CENTER – RADIOLOGY DEPARTMENT

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION: TODAY'S DATE: ____/____/____

Patient Name: _____ Date of Birth ____/____/____ Age: _____

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

Home Phone #: _____ Work Phone #: _____ Social Security #: _____

Sex: □ M □ F Marital Status: _____ Work Status:_____ Employer: _____

DESIRED METHOD OF PAYMENT:

□ Cash/Check □ Credit Card □ Insurance □ Other _____

Accident/Injury: □ Yes □ No Date of Accident: ____/____/____

Type of Accident: □ Work Related □ Auto □ Other _____

REFERRING DOCTOR:

Doctor's Name: _____

Doctor's Address: _____

_____

Doctor's Phone #: _____

Doctor's Fax #: _____

HISTORY:

Symptoms: _____

_____

Trauma: _____

Surgeries: _____

Cancer: □ Y □ N Type?: _____

Diagnosis: _____

Imaging/Laboratory Series Ordered: _____

_____

Radiographs Submitted: _____

INSURANCE INFORMATION:

Type of Insurance: □ Group Insurance □ Medicare □ Auto Insurance □ Worker's Comp □ Attorney □ Other _____

Name of Insured: _____ Address: _____

Insured's Social Security #: _____ Insured's Date of Birth ____/____/____ Relation to Insured _____

Insurance Carrier Name: _____ Contact/Attention: _____

Insurance Address: _____

Insurance ID #: _____ Group #: _____ Claim #: _____

Secondary Insurance: _____ I.D.#: _____ Group #: _____

AUTHORIZATION AND ASSIGNMENT TO PAY PHYSICIAN:

I hereby authorize the doctor to furnish you the information and evidence in the doctor's possession regarding my history and physical condition. I hereby authorize the release of any medical information necessary to process this claim and you are instructed to pay directly to the doctor, at the doctor's office, for all diagnostic and professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid amounts for diagnostic and consultant (x-ray interpretation) services. In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment. I fully understand that I am directly and fully responsible to said doctor for all diagnostic and professional bills submitted by him for services rendered to me and that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fees. Medicare regulations do not require x-rays and will not pay for these services.

Signature: X_____ _____

Patient's (or Authorized Representative) signature Date