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PATIENT INTAKE FORM

PATIENT INFORMATION

Patient MRN#:_____

Last Name: _____ First Name: _____ MI: _____ Gender: M / F

Marital Status: S M D W DOB: _____ SSN: _____-____-_____ County: _____ Race: _____

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

Home Phone: ____-____-_____ Mobile/Other: ____-____-_____ Date of onset of pain or injury: _____

May we send you an email to follow up on the quality of service we provide today? Y/N Email _____

PATIENT EMPLOYER INFORMATION

Status: Full Time Part Time Un-Employed Student Disabled Retired Date of Retirement: _____

Employer: _____ Work Phone: ____-_____-_____ Extension: _____

Employer Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____Phone: ____-____-_____Relationship to patient: _____

RESPONSIBLE PARTY (Complete if patient is under age of 18 years)

Name: _____ SSN: _____-___-_____ DOB: _____ Relationship to Patient: _____

Address (if different from patient): _____

PRIMARY INSURANCE INFORMATION

Insured Name: _____ DOB: _____ Relationship to Patient: _____

Insured Employer: _____ Address: _____ Ph#: _____

On the Job Injury: Y/N Motor Vehicle Accident: Y/N Date of Accident/Injury: _____ State accident occurred: _____

Group Name or Number: _____ Policy #: _____ Subscriber ID: _____

Insurance Company Name & Address: _____ Phone#: ____-____-_____

Worker's Comp Claim #: _____ Adjuster Name and Phone: _____

SECONDARY INSURANCE INFORMATION

Insured Name: _____ DOB: _____ Relationship to Patient: _____

Insured Employer: _____ Address: _____ Ph#: _____

On the Job Injury: Y/N Motor Vehicle Accident: Y/N Date of Accident/Injury: _____ State accident occurred: _____

Group Name or Number: _____ Policy #: _____ Subscriber ID: _____

Insurance Company Name & Address: _____ Phone#: ____-____-_____

Worker's Comp Claim #: _____ Adjuster Name and Phone: _____

I have reviewed the above information and verify that it is accurate.

Patient Signature: _____ Date: _____

Diagnostic Health Signature: _____ Date: _____

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PHYSICIAN ORDER (Verbal Only)

Ordering Physician: _____ Caller Name: _____

Verbal Order / Procedure(s): _____ Date: _____

Signs & Symptoms **(No Rule Out)**: _____

Verbal Order Received By: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I understand if I have provided complete and accurate information, Diagnostic Health will file both my primary and secondary insurance. I understand based on the agreement Diagnostic Health has with my insurance network and information they have received at the time of verification my co-pay/co-insurance amount due today is $_____. I also agree to be responsible for any additional co-share and or non paid amounts identified by my insurance after my claim has been processed. In the event legal action should become necessary, I agree to be financially responsible for all collection, attorney and court fees incurred.

I understand if the services provided today are being represented by an attorney, auto insurance and or third party payor, I am financially responsible for all charges incurred.

I authorize Diagnostic Health to release to my insurance company any medical information which may be necessary for processing my insurance claim. I also assign "benefits payable to" for my services today to Diagnostic Health.

I further authorize the release of any medical information in regard to the services which are provided by Diagnostic Health to any physician or health care provider by whom I have been or will be treated who request such information.

Scheduled Procedure(s): _____ Cost of Procedure(s): $_____

Patient/Guardian Signature: _____ Date: _____

Diagnostic Health Signature: _____ Date: _____

MEDICAL RECORDS AUTHORIZATION TO DISCLOSE

I authorize the disclosure of my medical records/information (individuality identifiable health information) to the persons listed below. I understand this is a voluntary request to release my health information to someone other than healthcare providers. I understand **only** the individuals identified below are authorized to receive copies, pick up my medical records or inquire about my account at Diagnostic Health (this includes my spouse, parents, family members, friends, children etc.). I also understand identification confirmation for any requesting individual will be confirmed and documented prior to the release of my record information.

1 _____ 2 _____ 3 _____

- Can Diagnostic Health leave information related to your account, appointment and or any other medical record information on your answering machine or voicemail? YES or NO (please circle)

I understand this Medical Records Authorization to Disclosure will expire SIX Years from today. I understand I can revoke this authorization at any time by notifying Diagnostic Health in writing. If I revoke this authorization, Diagnostic Health will not be liable for any release of records completed prior to my change of this authorization. My signature below confirms that I understand and agree to the above statements regarding Medical Records Authorization to Disclose.

_____ _____
Signature of patient, responsible party or patient's representative Date

_____ _____
Printed name for patient's representative (if applicable) Relationship to patient (if applicable)

_____ _____
Diagnostic Health Representative Signature Date