INDEPENDENT IMAGING

PATIENT INFORMATION SHEET

NAME: _____ MRN: _____ Last 4 digits of SSN: _____
SEX: _____ DOB: _____ AGE: _____

(Check the preferred contact method below)
☐ HOME PHONE: _____ ☐ WORK: _____
☐ CELL: _____ ☐ EMAIL: _____

HOME/MAILING ADDRESS: _____
CITY/STATE: _____ ZIP: _____

EMERGENCY CONTACT

FIRST NAME _____ MI _____ LAST _____
RELATIONSHIP _____ HOME PHONE _____ MOBILE _____

EHR INFORMATION

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
FLU SHOT: ☐ YES ☐ NO
When? _____
RACE: ☐ White ☐ Black or African American
☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Other _____
PREFERRED LANGUAGE:
_____
SMOKER: ☐ Current every day smoker ☐ Current some day smoker ☐ Unknown if ever smoked
☐ Former smoker ☐ Smoker, current status unknown ☐ Never smoked

REFERRING DOCTOR: _____ PHONE: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EXPLAIN CURRENT INJURY, COMPLAINT OR SYMPTOMS: _____
_____

IS THIS VISIT FOR TESTING DUE TO AN AUTO ACCIDENT? YES NO DATE: _____

1. **PRIMARY** INSURANCE CO:
INSURED'S NAME _____ INSURED'S DOB _____
INSURED'S SS# _____ YOUR RELATION TO INSURED _____

2. **SECONDARY** INSURANCE CO:
INSURED'S NAME _____ INSURED'S DOB _____
INSURED'S SS# _____ YOUR RELATION TO INSURED _____

I, the undersigned have insurance with the above listed company(s) and assign directly to **Independent Imaging** all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance company.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. **Medicare authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Independent Imaging** for any service furnished to me by that physician. I authorize any holder of medical information about me to release to the health care financing administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the hcfa form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer agency shown. In medicare assigned, the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____ _____
Patient Signature Print Name Date