IOWA RADIOLOGY - 2011

1. Patient Information

Patient Name ____
Last First MI

Soc. Sec. # ______________________ **Date of birth** _____________________ **Marital Status** _________

Address ____
Street/Apt # City State Zip

Sex: M_____ F_____ **Home Ph**. _________________________ **Work Ph**. ________________________

Cell Phone: _______________________

Employer ____

Physician Information:

Referring: ____

Any additional physicians you would like your report sent to: _______________________________

Have you had prior radiology services under a previous last name? If yes, please list: ______________

What exam are you having**?** _____________________ **Reason** for exam:___________________________

Emergency contact/Next of Kin information:

Name: ______________________________ Rel.: ________________ Phone #: ______________________

If patient is a minor please designate guarantor/responsible party information

Name: _____________________________ Rel: ________________ Date of Birth: ___________________

PLEASE SELECT ONE OF THE FOLLOWING:

Insurance policy is held by:

Self/Patient: ______ Spouse*: ______ Parent*: ______ Other* ______ No ins./Self pay: ______

***If insured is someone other than self/patient, please complete the following:**

Primary Ins: Name of insured person/employee: _______________________ Insured's DOB: __________

Insured person/employee Social Security #______________________

Insured persons Employer _________________________________

Secondary Ins: Name of insured person/employee: _____________________ Insured's DOB ___________

Insured person/employee Social Security#_______________________

PLEASE SIGN ON THE BACK PAGE

2. Insurance Information (only complete if you don't have your card/s)

Primary Insurance Company Name ______________________________

Policy Employer ____________________Policy # ____________________ Group # _______________

Secondary Insurance Company Name______________________________

Policy Holder's Information:

Employer ______________________Policy # ____________________ Group # ___________________

Work Related or Auto Accident Related Claim

Name of insurance company/employer handling work claim ___________________________________

Contact name: ____________________________ Contact Phone Number: _______________________

Address where claims are to be submitted:

____

3. Release of records and Authorization of Insurance Benefits

I give Iowa Radiology the consent to treat me as a patient in their facility. I hereby authorize any medical facility to release my previous x-ray films or mammograms and reports to Iowa Radiology for comparative purposes. In addition, I authorize Iowa Radiology to release my x-ray films and reports to any other facility for comparative purposes.

I give permission to release information requested by the insurance company to pay this claim. I hereby authorize payment directly to Iowa Radiology, the x-ray benefits herein specified and otherwise payable to me. In making this authorization, I understand that I will be held responsible for any unpaid balance not covered by my insurance carrier. I assume and agree to be responsible for an administrative fee when my account enters a default status and is considered "past due".

I am aware that Iowa Radiology is participating in the clinical education of students attending Iowa Health-Des Moines School of Radiologic Technologists. I consent to the receipt of services from students in the program. (Students will not be participating in clinical training in mammography or ultrasound).

____/   /2011_________

Patient (or legal guardian) **Signature** Date

____

Relationship (if not patient) Parent or legal guardians date of birth

Mammography Patients Only

If you need further work up following your screening mammogram such as additional views or ultrasounds, we will contact you to schedule an appointment at our Diagnostic Center located at 12368 Stratford Drive, Clive, Iowa. Please ask the technologist if you have any questions.

____/   /2011_________

Patient Signature Date