

Chart # _____

APPT BY: _____

Patient Name _____ DOB _____

Address _____ APT# _____ City _____ Zip _____

Phone # _____ SS# _____ Email: (appointment alerts) _____

| |
|---|
| Work status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student |
| Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |
| How were you referred to our office <input type="checkbox"/> Referring Dr <input type="checkbox"/> Internet <input type="checkbox"/> Zoc Doc <input type="checkbox"/> Returning Patient <input type="checkbox"/> ETC. _____ |

Employer _____ Employer's Address _____

Emergency contact person _____ phone # _____

INSURANCE INFORMATION

| | |
|---------------------------------------|--|
| Is this related to an accident | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes, <input type="checkbox"/> Auto, <input type="checkbox"/> W.Comp. <input type="checkbox"/> Other |
| Date of accident : _____ | State Auto Injury occurred in: _____ |

| | |
|--|--------------------------|
| Attorney Name: _____ | Phone# _____ |
| Are you treating with a Chiropractor <input type="checkbox"/> Yes <input type="checkbox"/> No | Name: _____ Phone: _____ |

PRIMARY

Authorization # _____

| | | |
|-----------------------|-------------------------|--------------------|
| Name Insurance: _____ | Id # _____ | Group # _____ |
| Phone # _____ | Insurance Address _____ | Adj Info _____ |
| Subscriber name _____ | D.O.B/ S.S.# _____ | Relationship _____ |

SECONDARY

Authorization # _____

| | | |
|-----------------------|-------------------------|--------------------|
| Name Insurance: _____ | Id # _____ | Group # _____ |
| Phone # _____ | Insurance Address _____ | Adj Info _____ |
| Subscriber name _____ | D.O.B/ S.S.# _____ | Relationship _____ |

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare patients) and all other third-party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand if my account is sent to collection for payment, I will incur additional charges (a minimum of 25%) on the amount sent; this applies to copayments as well. This is for today's service and any future services at North Dover Radiology. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

This facility will provide a locker in which you must store your personal items and valuables. Please lock these items in the area provided, and bring the key with you into the scan room for security. North Dover Radiology will not accept liability for any personal belongings.

I hereby authorize North Dover Radiology to deliver my imaging studies to the referring physician or specialist at his/her request. I understand that these studies are a permanent part of my medical record. I hereby release North Dover Radiology from any and all legal responsibility or liability that may arise from release of these films. I have been offered a copy of the HIPPA compliance and understand and agree to its terms.

Signature **Today's date**
All patients/legal guardians must REVIEW, SIGN and DATE all paperwork.