COMMUNITY RADIOLOGY ASSOCIATES

Community Radiology Associates

PATIENT INFORMATION FORM

Last Name: First Name: Middle Name:

MRN: DOB: Gender:

Address 1:

Address 2:

City: State: Zip Code:

Home Phone: Work Phone: Cell Phone: Email:

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Delivery Method: ☐ Mail ☐ Electronic Preferred Language:

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian

Are you: ☐ Hispanic ☐ Not Hispanic Referring Physician:

RESPONSIBLE PARTY INFORMATION

Last Name: First Name:

Patient's Relationship to Responsible Party: Phone:

Address 1:

Address 2:

City: State: Zip Code:

Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Insurance Name: Plan Name:

Address:

City: State: Zip:

Policy #: Group #:

Policy Holder's Name: Date of Birth:

Sex:

Policy Holder Address:

City: State: Zip:

Patient's Relationship to Policy Holder:

Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Insurance Name: Plan Name:

Address:

City: State: Zip:

Policy #: Group #:

Policy Holder's Name: Date of Birth:

Sex:

Policy Holder Address:

City: State: Zip:

Patient's Relationship to Policy Holder:

MEDICAL INFORMATION

Is this visit related to an auto accident? ☐ Yes ☐ No

Is this visit related to an injury sustained while at work? ☐ Yes ☐ No

Date of Injury: _____/_____/_____ Height: _____ ft. _____ in. Weight: _____

SMOKING STATUS:

☐ Current Every Day ☐ Current Some Days ☐ Never smoked ☐ Smoker, current status unknown ☐ Former smoker ☐ Unknown

ACTIVE MEDICATIONS: ☐ NONE *(It is not necessary to document medications not listed)*

☐ ACTOplus Met	☐ Diaformin	☐ Glumetza	☐ Janumet	☐ PrandiMet
☐ Avandamet	☐ Fortamet	☐ Glucovance	☐ Metaglip	☐ Riomet (liquid form of Metformin)
☐ Diabex	☐ Glucophage	☐ Glyburide-metformin	☐ Metformin	

MEDICAL HISTORY: ☐ NONE *(It is not necessary to document history not listed)*

☐ Aneurysm Clip / Coil	☐ Cancer	☐ Morphine Pump	☐ Renal Disease
☐ Aneurysm **Had Surgery**	☐ Diabetes	☐ Pacemaker	☐ Universal Precautions
☐ Aneurysm **NO Surgery**	☐ Hypertension	☐ Paraplegic	
☐ Asthma	☐ Insulin Pump	☐ Previous CT Contrast Reaction	
☐ Breast Implants	☐ Metal In the Body	☐ Previous MR Contrast Reaction	

ALLERGIES: ☐ NONE *(It is not necessary to document allergies not listed)*

☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	☐ Latex	☐ Mild	☐ Moderate	☐ Severe
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novocaine	☐ Mild	☐ Moderate	☐ Severe
☐ Betadine (Topical Iodine)	☐ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe
☐ Contrast (Med. Imaging)	☐ Mild	☐ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	☐ Moderate	☐ Severe
☐ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	☐ Moderate	☐ Severe
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	☐ Moderate	☐ Severe
☐ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe

Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes.
Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness.
Severe allergic reaction is anaphylactic shock.

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

_____ _____

Signature *Date*

Date of Last Menstrual Period: _____/_____/_____

AUTHORIZATION & AGREEMENT

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

_____ _____

Signature of Patient, or Personal Representative *Date*

COMMUNITY RADIOLOGY ASSOCIATES

Understanding Common Health Insurance Terms

While your health insurance plan covers fees for health care services, there may still be certain dollar amounts that you will be responsible for paying, including deductibles, co-pays and co-insurance.

Deductible

A deductible is a dollar amount established by your health insurance plan that you are required to pay out-of-pocket before your plan kicks in and starts to pay for your health care services.

Example: Your health plan has a $1,500 deductible. This means you must pay 100% of your health care fees until you spend $1,500. Once you meet your deductible, then your insurance plan will begin paying the fees for your health care services. However, each insurance plan is different, and some plans may pay for 100% of the fees for services, while others may only pay a percentage. In addition, you may still be responsible for paying co-insurance or co-pays established by your health plan.

Co-Pay

A co-pay is a set dollar amount that you must pay for each doctor visit, prescription, medical equipment or other health care service. Your co-pay is usually due at the time of service and may vary by the type of service you receive.

Example: Your co-pay for a visit to the doctor's office might be $40; while a prescription co-pay could be only $10, and an emergency room visit may be $100. Your insurance plan establishes a maximum dollar amount that you will pay out-of-pocket for co-pays.

Co-Insurance

Co-insurance is your share of the cost for a health care service after you have met your deductible and co-pay fee. Some health plans may have an 80/20 co-insurance, while others may have a 50/50 co-insurance.

Example: You have met your $1,500 deductible and paid your $40 co-pay for an office visit. Your co-insurance is 80/20 and you have a $100 medical bill. This means you are responsible for paying $20 and your health plan pays the remaining $80 of the bill.

Out-of-Pocket Limit

Out-of-Pocket Limit is the maximum amount of money you will pay for medical services in a policy period, which is usually one year. Once you meet the out-of-pocket limit, your health plan starts to pay 100% for covered health services.

Please contact your health plan with specific questions about your insurance coverage.