Denver Integrated Imaging

PATIENT INFORMATION

DATE _____/_____/_____ CHART _________________

ALL PATIENTS:
**ALL VALUABLES SHOULD BE LEFT AT HOME OR WITH A FAMILY MEMBER. THE FACILITY WILL NOT BE HELD RESPONSIBLE FOR ANY LOST STOLEN OR DAMAGED ITEMS DURING YOUR VISIT TODAY.

PLEASE PRINT CLEARLY, IF YOU NEED ASSISTANCE WITH THIS FORM PLEASE ASK THE RECEPTIONIST.

PATIENT NAME____ AGE ________

ADDRESS ____

CITY____________________________________STATE_____________ ZIP ____________

HOME PHONE_____________________ WORK/CELL/MSG ___________________________
DATE OF BIRTH_____________________ SOCIAL SECURITY ___________________________

(PLEASE CIRCLE ONE) MARRIED DIVORCED SINGLE WIDOWED

EMPLOYER NAME____
EMPLOYER ADDRESS____
EMPLOYER PHONE ___________________________ OCCUPATION ______________________

SPOUSE **OR** NEXT OF KIN____
ADDRESS ____
CITY ___________________________________ STATE ____________ ZIP ________________
PHONE: ________________________________

EMERGENCY CONTACT: ________________________________ **PHONE:**_______________

PRIMARY INSURANCE

NAME OF INSURANCE ____
INS. CLAIM ADDRESS ____
CITY ____ ST ____________ ZIP __________
INSURANCE PHONE # ______________________________
POLICY #______________________________________ GROUP # _________________________

POLICYHOLDERS NAME:_____________________________________ **D.O.B.** _____________
SS# ___________________________________
POLICYHOLDERS EMPLOYER____
EMPLOYERS PHONE ____

RELATIONSHIP TO INSURED (PLEASE CIRCLE ONE) SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE

NAME OF INSURANCE CARRIER ____
INS. CLAIM ADDRESS ____
CITY ____________________________________ STATE__________ ZIP _______________
INSURANCE PHONE ____
POLICY # ______________________________________ GROUP __________________________

POLICYHOLDERS NAME ____ **D.O.B.** _____________
SS# ____
POLICYHOLDERS EMPLOYER ____
EMPLOYERS PHONE # ____

RELATIONSHIP TO INSURED (PLEASE CIRCLE ONE) SELF SPOUSE CHILD OTHER

ACCIDENT/INJURY INFORMATION

IS YOUR VISIT TODAY THE RESULT OF ACCIDENT/INJURY? YES ______ NO _______
IF YOU ANSWERED YES, IS THIS ACCIDENT/INJURY RELATED TO:
WORK _______ AUTO ______ HOME ______ OTHER______

DATE OF INJURY _______/_______/_______
STREET & CITY, STATE OF ACCIDENT____

DO YOU HAVE AN ATTORNEY? YES _____ NO ______
NAME OF ATTORNEY ____
ATTORNEYS ADDRESS ____
ATTORNEYS PHONE # ______________________________________

AUTO INSURANCE ____
INSURANCE BILLING ADDRESS ____
INSURANCE PHONE # ____________________________ ADJUSTERS NAME _______________________

POLICY HOLDERS NAME ____
POLICY #____ CLAIM # ______________________________

PLEASE GIVE A BRIEF DESCRIPTION OF HOW ACCIDENT/INJURY OCCURRED. ______________________
____
____
____

WORKERS COMPENSATION INFORMATION (IF WORK RELATED)

INSURANCE CARRIER ____
ADDRESS ____
CITY _______________________________________ STATE ___________________ ZIP _______________
INSURANCE PHONE _____________________________ ADJUSTERS NAME __________________________
CLAIM # _______________________________________ DATE OF INJURY ______/______/______

EMPLOYER AT TIME OF ACCIDENT ____
EMPLOYERS ADDRESS ____
PHONE __________________________________

MEDICAL RECORDS CONSENT:

I AUTHORIZE THIS FACILITY TO RELEASE ANY MEDICAL RECORDS TO MY PHYSICIANS, THIRD PARTY PAYERS, INCLUDING BUT NOT LIMITED TO INSURANCE COMPANIES, WORKERS COMPENSATION AND OTHER PARTIES.

I AUTHORIZE ANY PHYSICIAN, HOSPITIAL, CLINIC OR OTHER PROVIDERS TO RELEASE ANY REPORTS AND/OR OTHER MEDICAL RECORDS, X-RAY AND/OR ANY FILM TO THIS FACILITY.

ASSIGNMENT OF BENEFITS

I AUTHORIZE AND IRREVOCABLY ASSIGN ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO THIS FACILITY UNDER SAID INSURANCE POLICY (IES) INCLUDING MAJOR MEDICAL BY REASON OF SERVICES RENDERED THEREIN.

IT IS UNDERSTOOD AND AGREED THAT ANY SUM OF MONEY PAID BY THE INSURANCE COMPANY SHALL BE CREDITED TO MY ACCOUNT AND IN THE EVENT THE SUM IS INSUFFICIENT TO LIQUIDATE THE SAID AMOUNT I SHALL BE PERSONALLY LIABLE FOR THE BALANCE OF THE ACCOUNT.

PATIENTS NAME (PLEASE PRINT) ____
DATE OF BIRTH ______/_______/_______
SOCIAL SECURITY # ____

PATIENT SIGNATURE ____ DATE__________________________
PARENT OR GUARDIAN____ DATE__________________________

(IF PATIENT IS A MINOR)

A PHOTO COPY OF THIS AUTHORIZATION WILL SERVE AS THE ORIGINAL