

# IOWA RADIOLOGY - 2010

## 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. \_\_\_\_\_

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).

\_\_\_\_\_/\_\_\_\_\_/2010  
**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.

\_\_\_\_\_/\_\_\_\_\_/2010  
**Patient Signature** Date