Date: ____________

PATIENT INFORMATION

Name:____#________________________
Last First Middle Social Security Number

Date of Birth:______________________Sex:_______ Circle one: Single Married Divorced Widowed

Home Address:____
Street City State Zip

Home Phone:_______________________________Occupation:_______________________

Employer:____Work Phone:_____________

Work Address:____
Street City State Zip

Allergies:____

Current Prescriptions:____

Medical Conditions:____

PRIMARY INSURANCE HOLDER

Circle One: Self Spouse Parent Other Date of Birth:__________________________Sex:____________

Name:____#________________________
Last First Middle Social Security

Address:____
Street City State Zip

Employer:____Occupation:________________

Work Address:____

Home Phone:______________________________________Work Phone:_______________

I understand that I am financially responsible for all charges, and that payment is expected at the time of service.

X__________________________________
(signature)

I hereby authorize the physician to furnish information to insurance carriers concerning this and other subsequent visits.

X__________________________________
(signature)

Patient Name: ________________________________ Date: ______________________________

Feel free to ask any questions you may have at the time of your exam.

<u>Try to be specific and use as many dates as you can.</u>

Date Symptoms started or Date of incident:

____

____

Symptoms &/or Change in symptoms:

____

____

____

Recent Treatments/Medications used? Are they relieving your symptoms?

____

____

____

Past Injuries to Area:

____

____

Do You Have a History of Cancer?

____

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No
If yes, please indicate the date and type of surgery:

Date:____________________ Type of Surgery:____
Mo. Day Yr.

Date:____________________ Type of Surgery:____
Mo. Day Yr.

Do you have a follow up appointment scheduled with your doctor? Yes No
If yes, Date:________________________ Time: ___________________________

Patient Signature Form

Verification of Document Receipt
Privacy Notice and
Patients Rights and Responsibilities

I have been given he opportunity to read a copy of the "Privacy Notice" and "Patient Rights and Responsibilities." I understand that if I have any questions regarding these documents I may call NORTH STAR DIAGNOSTIC IMAGING at 214-618-3420 or 972-954-8001 for additional explanation.

Signature of Patient of Guardian: ______________________________ **Date:** ________________

Assignment of Insurance Benefits and Release of Information for Billing Purposes

I, the undersigned, have insurance coverage with ________________________ and assign directly to NORTH STAR DIAGNOSTIC IMAGING, SOUTHWEST IMAGING AND INTERVENTIONAL SPECIALIST AND/OR NORTH TEXAS RADIOLOGY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient or Guardian: ______________________________ **Date:** ________________

Patient Request of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted at the following number: ______________________________

Please circle all that apply:

OK to leave message with detailed information

Leave message with call-back number only

Signature: ______________________________ **Date:** ______________________________

NORTH STAR STAFF SIGNATURE: ______________________ **Date:** ____________________