Dr. Adam G. Crouch Inc dba, Diagnostic Medical X-Ray & Imaging

8390 Tod Avenue Boardman, OH 44512 (330) 726-6010

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DATE: _____ **PATIENT NAME:** _____

ADDRESS: _____ **CITY/STATE/ZIP CODE** _____

PHONE NUMBER: HOME: _____ **CELL:** _____

DOB: _____ **AGE:** _____

Language of preference: English / Other: _____

Race: Asian / Native Hawaiian / Other Polynesian / African-American / Native American / White / More than One / Unknown

Ethnicity: Hispanic / Non-Hispanic

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List of Medications: _____ _____

_____ _____

_____ _____

Are you allergic to any medications: Yes / No. Which drugs?

_____

Are you diabetic? Yes / No

Do you smoke? Yes / No

Circle one: Current- every-day smoker / current- occasional smoker / former smoker / never smoked

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What symptoms caused you to have this exam today?

_____

_____

When did symptoms start? _____

Due to: Worker/s Comp / Auto Accident / Other _____

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Primary Insurance: _____

Employer: _____

Policy holder's name: _____

Policy holder's DOB: _____

Policy holder's SS #: _ _ _ - _ _ - _ _ _ _

Relationship: self / spouse / child / other

Secondary insurance: _____

Employer: _____

Policy holder's name: _____

Policy holder's DOB: _____

Policy holder's SS #: _ _ _ - _ _ - _ _ _ _

Relationship: self / spouse / child / other

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that my protected health information may be used by the practice as described in the Practice's HIPAA notice. There is a copy available for you to read in the folder on the table in the waiting room. If you would like a copy of the Practice's HIPAA notice, please ask the receptionist. I give permission for DMXI to leave message on my answering machine.

Patient's Name: _____

Patient's Signature: _____

Date: _____

I allow the following people to have access to my health information:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

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How did you hear about DMXI?

Doctor / Friend / Radio / Billboard / Other: _____

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Financial Policy

Please take a moment to read, understand and sign the following financial policy. We request that you provide us with complete and accurate information at the time of registration so that we may prepare and file the appropriate forms needed to complete your examination.

This form is used to advise you that you are ultimately responsible for any personal balances showing on your account.

Unfortunately, there is no way for us to know the guidelines of your insurance policy, therefore you will be solely liable for these charges should your insurance company not cover this examination due to age, frequency, or other reasons your insurance deems unnecessary.

Personal balances must be paid on a monthly basis which may be divided into 3 equal consecutive payments. You will receive 3 monthly statements, if payment has not been made on the account, it will be turned over to a collection agency.

I have read, understood and agreed to the above HIPAA privacy notice and the financial policy. I hereby authorize Dr. Adam G. Crouch Inc dba Diagnostic Medical X-Ray & Imaging (DMXI) to furnish information to insurance carriers, attorneys, etc. concerning my exam, treatments, illness, including but not limited to the professional interpretation generated as a result of this exam, and hereby assign all payments for medical services rendered to myself and/or my dependent.

Signature: _____ **Date**: _____