Steinberg Diagnostic Medical Imaging
Patient Information Form

Referring Physician: _____

Patient Name_____

Social Security Number _____-____-_____ Birth Date____/_____/____ Age: _____ Sex: _____

Patient Address: _____ Apt #: _____

City: _____ State: _____ Zip_____ Email: _____

Home Phone: _____Work Phone: _____ Cell Phone: ___ _____

Preferred Contact Phone (Please circle one): Home / Work / Mobile Employer: _____

Parent / Guardian Information

Is Patient a Minor: _____ (If Yes, Parent / Guardian Information and Signature Are Required)

Parent / Guardian Name: _____

Parent / Guardian Social Security Number #:_____-____-_____ Sex: _____ Birth Date: _____/_____/_____

Relationship: _____ Phone: _____

Address: _____ Apt #: _____

Employer: _____ Employer Phone: _____

Emergency contact: Nearest relative not living with you

Name: _____ Relation: _____ Phone: _____

Insurance Information

We will need your current insurance card and your driver's license or photo ID.

Primary Insurance

Insurance Name: _____

Insurance ID# _____ Group#:_____ Effective Date: __ _____

Insured's Name: _____ Relationship to Patient _____ _____

Insured's Social Security #: _____-_____-_____ Insured's Birth Date: _____/_____/_____ Sex _____

Insured's Employer: _____

Secondary Insurance

Insurance Name: _____ __ _____

Insurance ID# _____Group#:_____ Effective Date: _____

Insured's Name: _____ Relationship to Patient _____

Insured's Social Security #: _____-_____-_____ Insured's Birth Date: _____/_____/_____ Sex _____

Insured's Employer: _____

Signature

I agree that the above is true to the best of my knowledge. Patient or Parent / Guardian

Signature: _____Date_____

Steinberg Diagnostic Medical Imaging Financial & Health Information Policy

Dear Patient

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign our Financial Policy prior to having an exam.

Cash Patients – payment for services are due at the time services are rendered.

Insured Patients – co-pays, deductibles, and/or co-insurances are due at the time services are rendered. We accept cash, checks, MasterCard, Discover, VISA, or Am. Express for your convenience.

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up. All insured patients are required to sign the assignment of benefits for payment from the insurance company. Your final balance is determined after your insurance company processes your claim.

Returned checks will be subject to a $25.00 fee.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for any costs, including collection fees, interest, court costs, and other fees associated with collecting the debt.

Assignment & Transfer of Benefits

I hereby guarantee payment of all charges incurred at the office of Steinberg Diagnostic Medical Imaging. I hereby transfer and direct to pay any and all benefits for medical services provided by SDMI directly to Steinberg Diagnostic Medical Imaging. I hereby authorize the release of medical information required to process my claim.

I have read and agree to the terms spelled out in the financial policy and benefits transfer. I understand that this assignment applies to all services performed at Steinberg Diagnostic Medical Imaging and is in effect until specifically revoked in writing. I further agree that I will ultimately be responsible for payment for all charges incurred should my insurance company fail to pay.

Signature of Patient / Patient's Representative_____ Date: _____

Reason Patient Unable to Sign:_____

Relationship to Patient:_____

Health Information Policy

I have received a copy of Steinberg Diagnostic Medical Imaging's (SDMI) Notice of Health Information Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand that SDMI may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time and place of scheduled appointments, or other healthcare related communications. SDMI has an appointment reminder system in place utilizing the email you have provided us**.** You may **opt** out of this system if you do not want to receive email messages, in that case you will receive a phone call as an appointment reminder. If you wish to opt out of appointment email reminders, please call 702-732-6000

I understand that SDMI may disclose health information with other entities, such as my insurance company for purposes of treatment, payment, or business operations.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until specifically revoked in writing:

_____

_____

Signature of Patient / Patient's Representative _____Date_____

Reason Patient Unable To Sign_____

Relationship To Patient: _____

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Form printed on: 09/16/13

Steinberg Diagnostic Medical Imaging Centers

Patient Name: _____

Medical Information Form

Please provide us with some basic medical information. SDMI has implemented an electronic health record for our patients. The information below is required for your chart . Ask us how you can access your information online.

Patient Demographic Data

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Pac Islander/Hawaiian ☐ American Indian / Alaska Native ☐ More than one Race ☐ Refused

Ethnicity: ☐ Latino/Hispanic ☐ Other ☐ Not reported / Refused

Tobacco Use

Which, If any, tobacco products do you use? (Choose all that apply)

Tobacco Product: ☐ Do not use tobacco ☐ Cigar ☐ Cigarettes ☐ Smokeless Tobacco ☐ Hookah ☐ Refused ☐ Unknown

If you do use tobacco, has your doctor offered you information on quitting? ☐YES ☐ NO

Medications

Please list any prescription medications you are currently taking as well as the dosage and how often you take it (If you cannot remember the dosage, just leave it blank)

Medication	Dosage / How often?

Allergies

Please list any allergies you have to medication and describe the reaction (rash, nausea, etc.) If none, just write none.

Medication	Reaction

Signature _____ Date: _____