LOGAN UNIVERSITY
HEALTH CENTERS

DEPARTMENT OF RADIOLOGY
PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

_____ _____

Patient's First Name *Middle Initial* *Last Name* *Date of Birth*

_____

Patient's Address

Gender □ *Female* □ *Male*

_____ _____

City *State* *Zip* *Patient's Telephone*

_____ _____

Insurance Company *INSURANCE ID #*

_____ _____ _____

Name of Insured *Insured's Date of Birth* *INSURANCE GROUP #*

PATIENT' S HISTORY

_____

Present Symptoms (Reason for imaging study)

_____

Surgeries *Trauma*

History of Cancer? □ *Yes* □ *No* *Type* _____ *Date* _____

REFERRING DOCTOR

*Referring Doctor*_____

*Referring Doctor's Address*_____ *Suite* _____

City, State, Zip _____

Telephone _____ *Fax* _____

AUTHORIZATION AND ASSIGNMENT TO PAY PHYSICIAN:

I hereby authorize the doctor to furnish you the information and evidence in the doctor's possession regarding my history and physical condition. I hereby authorize the release of any medical information necessary to process this claim and you are instructed to pay directly to the doctor, at the doctor's office, for all diagnostic and professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid amounts for diagnostic imaging services. In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment. I fully understand that I am directly and fully responsible to said doctor for all diagnostic and professional bills submitted for services rendered to me and that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fees. Medicare regulations do not require x-rays and will not pay for these services.

_____ _____

PATIENT'S (OR AUTHORIZED REPRESENTATIVE) SIGNATURE *DATE*