MUNSTER
MEDICAL IMAGING

Patient Registration

X-Ray | Please print clearly or fill in on your device

PATIENT INFORMATION

Last name | First name | M.I. | Date of birth (MM/DD/YYYY)

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street address

City | State | ZIP code

Cell phone | Home phone | Email

Social Security # | Referring physician

INSURANCE

Primary insurance | Member ID | Group #

Policy holder name | Policy holder date of birth | Relationship to patient

EMERGENCY CONTACT

Name | Relationship | Phone

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Munster Medical Imaging. I understand that I am responsible for any charges not covered by my insurance. I also authorize the release of any medical information needed to process my insurance claims.

Patient or guardian signature | Date

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Patient Questionnaire

X-Ray

ABOUT YOUR EXAM

Exam being performed

Height

Weight

Please describe your symptoms

How and when did this happen?

HEALTH HISTORY

Surgery in the area being scanned	☐ Yes	☐ No
Cancer or tumor	☐ Yes	☐ No
Chemotherapy or radiation therapy	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Lung problems	☐ Yes	☐ No
Heart or blood pressure problems	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Kidney failure or dialysis	☐ Yes	☐ No
Are you, or could you be, pregnant?	☐ Yes	☐ No

If you answered yes to any of the above, please explain

Have you had a prior CT, MRI or X-ray of this area?	☐ Yes	☐ No

If yes, when and where?

How did you hear about us? ☐ Physician ☐ Family ☐ Friend ☐ Online ☐ Other

Patient or guardian signature

Date

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Privacy Practices Acknowledgment

Health Insurance Portability and Accountability Act (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in my care.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have been offered the Notice of Privacy Practices, and I understand that I may contact Munster Medical Imaging at any time to request a current copy. The Notice is also available at munstermri.com/privacy.html.

I understand that I may request in writing how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations by Munster Medical Imaging.

Patient name (print)

Date of birth

Patient or guardian signature

Date

If signed by a representative, name and relationship to patient