KENOSHA RADIOLOGY CENTER

To obtain copies of your images and/or reports, please contact us at (262) 697-7770.

PATIENT REGISTRATION FORM
PLEASE PRINT

PATIENT INFORMATION

FIRST NAME | MIDDLE INITIAL | LAST NAME

SOCIAL SECURITY NUMBER | BIRTH DATE | AGE | MARITAL STATUS | SEX

STREET ADDRESS | CITY | STATE | ZIP CODE | PHONE # ( )

PATIENT OR PARENT EMPLOYER | BUSINESS PHONE ( ) | CELL PHONE ( )

POLICY HOLDER OR PARENT INFORMATION

POLICY HOLDER'S OR PARENT'S NAME | SS# | BIRTH DATE

POLICY HOLDER'S OR PARENT'S STREET ADDRESS **(IF DIFFERENT FROM PATIENT ADDRESS)** | CITY | STATE | ZIP CODE

POLICY HOLDER'S OR PARENT'S EMPLOYER | BUSINESS PHONE ( )

INSURANCE INFORMATION

If you are covered by more than one insurance plan it is important that you indicate all policies.

PRIMARY	**SECONDARY**
RELATIONSHIP	RELATIONSHIP
NAME OF INSURANCE CO.	NAME OF INSURANCE CO,
WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY / INDUSTRIAL CLAIM #
WERE YOU IN AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO	DATE / NAME OF INSURER

PRIMARY CARE PHYSICIAN | REFERRED BY

CC: REQUEST FOR RESULTS TO ANOTHER PHYSICIAN: (PHYSICIAN NAME) _____

PLEASE ANSWER THE FOLLOWING MEANINGFUL USE QUESTIONS:

RACE:

- [ ] AMERICAN INDIAN OR ALASKA NATIVE
- [ ] ASIAN
- [ ] BLACK OR AFRICAN AMERICAN
- [ ] HAWAIIAN OR PACIFIC ISLANDER
- [ ] WHITE

ETHNICITY:

- [ ] HISPANIC OR LATINO
- [ ] NOT HISPANIC OR LATINO

LANGUAGE

- [ ] ENGLISH
- [ ] SPANISH
- [ ] ARABIC
- [ ] CANTONESE
- [ ] HEBREW
- [ ] JAPANESE
- [ ] KOREAN
- [ ] MANDARIN
- [ ] RUSSIAN
- [ ] Other _____

SMOKING STATUS

- [ ] Current every day smoker
- [ ] Current some days smoker
- [ ] Former smoker
- [ ] Never smoked

FOR FEMALE PATIENTS:

Are you currently pregnant or breastfeeding?

- [ ] Yes
- [ ] No

FOR ALL PATIENTS 50 YEARS AND OLDER:

Have you had appropriate screening for colorectal cancer?

- [ ] Yes
- [ ] No
- [ ] Unknown

FOR ALL PATIENTS 64 YEARS AND OLDER:

Have you ever received a pneumococcal vaccine (pneumonia vaccine)?

- [ ] Yes
- [ ] No
- [ ] Unknown

FOR FEMALE PATIENTS AGES 40-69:

Have you had a mammogram to screen for breast cancer?

- [ ] Yes
- [ ] No
- [ ] Unknown

FOR ALL PATIENTS:

Please list your current medications _____

_____

Are you allergic to any medications?

- [ ] No
- [ ] Yes - Please list _____

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY

I hereby assign to Kenosha Radiology Center, LLC. (KRC) any insurance or other third-party benefits available for health care services provided to me or my dependent(s). I also understand that if benefits are assigned, or if by contractual arrangement, payment to KRC will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that it is my responsibility to know my insurance benefits and whether or not the services I or my dependent(s) are to receive are a covered benefit. I understand and agree that my insurance company is being billed as a courtesy and hereby accept financial responsibility for any services rendered that are not covered under my insurance, and for any balance due that KRC is unable to collect from my insurance carrier(s) for whatever reason.

I hereby authorize and direct my insurance carrier(s) to pay directly to Kenosha Radiology Center, LLC. any benefits due me under my insurance plan(s). If benefits are not assigned to KRC, I agree to forward to KRC all insurance or benefit payments that I receive for services rendered immediately upon receipt and/or to make payment, in full, for the services rendered. I understand that KRC has the right to refuse or accept assignment of such benefits (except when prohibited by contract).

I also hereby authorize KRC to use and disclose any of my personal medical information for treatment and payment (including to my insurance company(ies). Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law and I agree to pay actual attorney's fees and collecting expenses. IF I AM UNINSURED, I understand I am fully responsible for all charges.

It is mandatory that you tell KRC if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Kenosha Radiology Center, LLC. on my behalf.

LAB:
I understand that I may receive a separate bill if my medical care includes lab services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

_____ _____

Signature **Date**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. As indicated below, I hereby authorize a Kenosha Radiology Center, LLC. representative to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to cancel this authorization at any time by notifying Kenosha Radiology Center, LLC. to that effect in writing.

Home Telephone

- ☐ **Ok to leave message with detailed information**
- ☐ **Leave message with call-back number only**
- ☐ **Do not leave message on home phone**
- ☐ **Do not call home phone**

Written Communication

- ☐ **Ok to mail to home address**
- ☐ **Ok to fax to _____**
- ☐ **Do not mail to home address**
- ☐ **Ok to mail to _____**

Work Telephone

- ☐ **Ok to leave message with detailed information**
- ☐ **Leave message with call-back number only**
- ☐ **Do not leave message on work phone**
- ☐ **Do not call work phone**

Cell Phone

- ☐ **Ok to leave message with detailed information**
- ☐ **Leave message with call-back number only**
- ☐ **Do not leave message on cell phone**
- ☐ **Do not call cell phone**

_____ _____

Patient Signature **Date**