DMXI <u>Dr. Adam G. Crouch Inc. dba Diagnostic Medical X-Ray & Imaging</u>

Form must be entirely completed.

Date: ___________ M / F Age: _____ Date of Birth: _______________

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

Ethnicity: Hispanic / Non-Hispanic Language of Preference: English / Other: _______________

Patient Name: ______________________________ SS# ___-__-____

Address: ____
(City) (State) (Zip code)

Home phone #: ___-___-____ Cell Phone# : ___-___-____

E-mail: ______________________________

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List of Medications:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Are you allergic to any medications? Yes / No

If so, which drugs: ____

____

Are you diabetic? Yes / No Recent bloodwork? Yes / No Date: _____________

Do you smoke?

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

This section must be completed in order to bill your insurance company:

What symptoms caused you to have this exam today?

____

____

When did these symptoms and / or injury start? __/__/____

Is this due to: Workers Comp / Auto accident / Other: ____________________

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Primary Insurance: ____________________ Employer: ________________

Policyholder's name: ____________________ Date of birth: ______________

SS#: ___-__-____ Relationship: Self / Spouse / Child / Other

Secondary insurance: ________________ Employer: ________________

Policy holder's name: ________________ Date of birth: ______________

SS#: ___-__-____ Relationship: Self / Spouse / Child / Other

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HIPAA Privacy Notice

I acknowledge that I have received Dr. Adam G. Crouch Inc dba DMXI's notice of privacy practices. I also give my permission to leave messages on my answer machine.

____ Date: ______________

Signature of patient of authorized representative

Printed Name: ___________________________

Dr. Adam G. Crouch D.O. Inc DBA
Diagnostic Medical X-ray and Imaging

NOTICE OF PRIVACY PRACTICES FOR
PROTECTED HEALTH INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered and/ or received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

Patient Name: ______________________________

Patient Signature: ______________________________

Date: ______________________________

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

______________ Relationship ______________ Phone __________

______________ Relationship ______________ Phone __________

______________ Relationship ______________ Phone __________

______________ Relationship ______________ Phone __________

YES or NO: I also give permission for the above named signatures to have access to my appointment and/or billing information.