anatomi imaging
a Via Christi Health Partner

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Wichita, KS
www.anatomiimaging.com

# Patient Information Form

Last Name _____ First Name _____ M.I. ____

Appointment Date _____ Location _____

*YYYY-MM-DD*

## Patient Information

*If you are filling this form out by hand, please use print handwriting.*

Date of Birth _____ ◯Male ◯Female

Address _____ Apt. _____ City _____ State _____ Zip _____

Marital Status _____ Home Phone _____

Work Phone _____ Extension _____ Cell Phone _____

Employer _____ ◯FT ◯PT ◯Not Employed

Employer Address _____

Physician's Name _____ Pregnant: ◯Yes ◯No

Allergies _____

Is this visit due to an injury? ◯Yes ◯No If yes, what was the date of the injury? _____

How did it happen? _____

Where did it happen? _____

Workers Compensation: ◯Yes ◯No Motor Vehicle Accident: ◯Yes ◯No

## Emergency Contact Information

Name _____ Address _____ Apt. _____

City _____ State _____ Zip _____ Home Phone Number _____

Work Phone _____ Relationship _____ Legal Guardian: ◯Yes ◯No

## Subscriber Information

*If different from patient*

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ ◯Male ◯Female

Address _____ Apt. _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Extension _____

Employer _____ ◯FT ◯PT ◯Not Employed

## Responsible Party Information

*For Billing*

◯Same as Patient ◯Same as Insured ◯Other: Name _____ Phone: _____

Address _____

## Consent Agreement

I consent to the diagnostic testing by Anatomi Imaging personnel. I agree that all records concerning my care remain property of Anatomi Imaging. Anatomi Imaging may release confidential information to health insurance providers liable for test charges. I authorize the release of any medical or other information necessary to process this claim for payment or other business operations. I authorize insurance, Medicare, or Medicaid benefits to be paid directly to Anatomi Imaging. I understand that I am responsible for co-insurance payments, deductibles, and/or remaining balance as specified by my health plan. This signature may be photocopied to process all insurance claims.

☐ I have read and understand Anatomi Imaging's Notice of Privacy Practices - Patient Summary.

Patient's Signature _____

*To be signed at the time of your appointment*

Print

Save

Submit