SANTA FE IMAGING

Date:

PATIENT INFORMATION

DOB: SSN:

Name: First Last Gender: ☐ Male ☐ Female ☐ Non-binary/Other

Address: City: State: Zip:

Phone: Mobile: Work:

Email: Preferred Language:

Needs Interpreter: ❒ Yes ❒ No Primary Provider:

Marital Status: ❒ Divorced ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed ❒ Unknown

Religion:

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Decline to Specify ❒ Unknown

Race: ❒ Asian ❒ Black or African American ❒ Indian Or Alaskan Native ❒ Native Hawaiian or Pacific Islander

❒ White or Caucasian ❒ Unknown ❒ Refuse ❒ Other

Special Needs: ❒ Yes ❒ No

Guarantor/Insurance Subscriber Information

Name: First Last

DOB: SSN:

Relationship: Interpreter Needed: ❒ Yes ❒ No

Primary Phone: ❒ Home ❒ Work ❒ Mobile

Legal Guardian: ❒ Yes ❒ No Preferred Language:

SANTA FE IMAGING

Patient Employment

Employer:

Address: City: State: Zip:

Employment status: Employer Phone:

Emergency Contact

Name:
First Last

Relationship: Interpreter Needed: ❒ Yes ❒ No

Primary Phone: ❒ Home ❒ Work ❒ Mobile

Legal Guardian: ❒ Yes ❒ No Preferred Language:

Same Household: ❒ Yes ❒ No

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members.
By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Signature *Date*

Date of Last Menstrual Period:

AUTHORIZATION & AGREEMENT

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize Santa Fe Imaging, LLC to furnish the necessary medical or surgical treatments, or procedures, including diagnostic, x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment, diagnostic procedures in Santa Fe Imaging, LLC. I recognize that the physicians who practice at Santa Fe Imaging, LLC are not employees or agents of Santa Fe Imaging, LLC but are independent physicians. Santa Fe Imaging, LLC may delegate to these independent physicians those services physicians normally provide, and any questions relating to care my physician has given or ordered should be directed to him/her.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Santa Fe Imaging, LLC of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Santa Fe Imaging, LLC for charges not covered by this assignment. I also understand that Santa Fe Imaging, LLC is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claim.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize Santa Fe Imaging, LLC to release any information including information regarding diagnosis and treatment requested by the insurance company/doctor/hospital necessary to collect benefits under the policies stated at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing.

Signature of Patient or Person Representative *Date*