DIAGNOSTIC RADIOLOGY INSTITUTE OF KANSAS CITY BILLING FORM

Last Name:_____ MI:_____ First Name:_____ DOB:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone Number:(____)_____ Cell Number: (____)_____
SSN# _____ Sex: M F Marital Status: M S D W
Email Address _____

Employment Information:
Employment:_____
Address:_____
City:_____ State:_____ Zip:_____
Work Number: (____)_____ Work Status(circle): Full-Part-Disabled-Retired-Other

Guarantor Information: (Responsibly Party if NOT Patient)
Last Name:_____ First Name:_____ DOB:_____
Employer:_____
Address:_____
City:_____ State:_____ Zip:_____
Employer_____ Work Number: (____)_____

Insurance Information:
Self-Pay____ Health Insurance____ Automobile Insurance____ Workers Compensation_____
Date of Injury/Accident:_____ Claim Number:_____
Primary Insurance:_____ Payor ID#_____
Billing Address:_____
Phone Number: (____)_____ Contact:_____
Pre-Cert#_____ Policy#_____ Group Name:_____
Insurance Address _____

Accident and Injury Questionnaire:
Is your visit today related to: (Please Circle) Accident Injury Work Comp Other Illness
Date of Accident/Injury_____ Date of your first symptom:_____
Have you received treatment for this condition before?_____
If yes, please provide date of last treatment. _____
Describe how injury occurred. _____

Patient Signature:_____
Date:_____

FOR OFFICE USE ONLY:
Medical Record #_____ NDC: 0019-_____
CPT Code:_____ Study:_____ Addt'l Views:_____