

# 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: \_\_\_\_\_