

# Crawford Long Hospital – Radiology Pre-Registration Form

Scheduled Date: \_\_\_\_\_ Requesting Physician: \_\_\_\_\_  
Test to be Performed: \_\_\_\_\_ Date of Onset of Symptoms \_\_\_\_\_

## PLEASE COMPLETE EACH SECTION

### PATIENT INFORMATION

Patient's Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
County: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Advance Directive? LW \_\_\_\_\_ DPA \_\_\_\_\_

### EMPLOYER INFORMATION (If retired, please list retirement date).

Name: \_\_\_\_\_ Date of Employment: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Status: \_\_\_\_\_ Retirement Date: \_\_\_\_\_

### SPOUSE/NEAREST RELATIVE INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

### SPOUSE/NEAREST RELATIVE EMPLOYER INFORMATION (If retired, please list retirement date).

Employer Name: \_\_\_\_\_ Date of Employment: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Status: \_\_\_\_\_ Retirement Date: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION (Please list someone other than spouse).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

### INSURANCE INFORMATION (For Medicare or Worker's Compensation, please complete attached form).

**Primary** Insurance Company Name: \_\_\_\_\_  
Planholder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Claims Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Group Name: \_\_\_\_\_  
Phone # to Verify: \_\_\_\_\_ Phone # to Precert: \_\_\_\_\_

**Secondary** Insurance Company Name: \_\_\_\_\_  
Planholder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Claims Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Group Name: \_\_\_\_\_  
Phone # to Verify: \_\_\_\_\_ Phone # to Precert: \_\_\_\_\_

Revised:  
08/2003

Please fax completed form to: Crawford Long Hospital, Admissions Department  
Fax: (404) 686-4404 Phone: (404) 686-1573

**This section to be completed by Medicare patients only:  
MEDICARE SECONDARY PAYER QUESTIONNAIRE**

1. Are you receiving Black Lung (BL) benefits and the services being performed are covered by BL?  
Yes \_\_\_\_\_ No \_\_\_\_\_
2. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?  
Yes \_\_\_\_\_ No \_\_\_\_\_
3. Are services to be paid by a government program, such as a research grant?  
Yes \_\_\_\_\_ No \_\_\_\_\_
4. Was the illness/injury due to a work related accident/condition that is covered by Worker's Compensation? Yes \_\_\_\_\_ No \_\_\_\_ If yes, please complete Worker's Compensation Form.
5. Was illness/injury due to a non-work related accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of accident caused the illness/injury? \_\_\_\_\_  
**(If auto accident, please provide a copy of the police report).**

Date of Injury \_\_\_\_\_ Time of injury \_\_\_\_\_ Location \_\_\_\_\_

6. Was another party responsible for this accident or is no fault insurance available?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list information on Registration Form (previous page) in the **Insurance Information Section**.
7. Are you entitled to Medicare based on Age, Disability, or End Stage Renal Disease (ESRD)?  
Age \_\_\_\_ Disability \_\_\_\_\_ ESRD \_\_\_\_\_

**Please complete the appropriate section (Age, Disability, or ESRD):**

**AGE:**

1. Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please complete Employer Information section of Registration Form.
2. Is your spouse currently employed?  
If yes, please complete Spouse/Nearest Relative Employer Information section of Registration Form.
3. Do you have a Group Health Plan (GHP) based on your own or spouse's employment?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list information on Registration Form (previous page) in the **Insurance Information Section** on previous page.
4. Does the employer that sponsors your GHP employ 20 or more employees? Yes \_\_\_\_\_ No \_\_\_\_\_

**DISABILITY:**

1. Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Is a family member currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Do you have a GHP based on your own or family member's current employment?  
Yes \_\_\_\_\_ No \_\_\_\_\_
4. Does the employer that sponsors your GHP employ 100 or more employees? Yes \_\_\_\_ No \_\_\_\_\_

**(continued on next page)**

**ESRD:**

1. Have you received a kidney transplant? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list date of transplant \_\_\_\_\_
2. Have you received maintenance dialysis treatments, self-dialysis training, or both?  
Self-Dialysis \_\_\_\_\_ Maintenance Dialysis \_\_\_\_\_ Both \_\_\_\_\_
3. Do you have a Group Health Plan (GHP) based on your own or spouse's employment?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list information on Registration Form (previous page) in the **Insurance Information Section** on the first page.
4. Are you within the 30 month coordination period? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list first Date of Dialysis \_\_\_\_\_
5. Are you entitled to Medicare on the basis of [End Stage Renal Disease (ESRD) and age] or [ESRD and disability]? ESRD and Age \_\_\_\_\_ ESRD and disability \_\_\_\_\_
6. Was your initial entitlement to Medicare based on ESRD? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Is the primary GHP based on age or disability entitlement?  
Age \_\_\_\_\_ Disability \_\_\_\_\_

**This section to be completed by Worker's Compensation patients only.**

**EMPLOYER INFORMATION** (At time of accident/injury)

Name: \_\_\_\_\_ Date of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Contact person \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of injury \_\_\_\_\_ Time of injury \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Claim # \_\_\_\_\_ Claims Adjustor's Name \_\_\_\_\_

Phone # to Verify: \_\_\_\_\_ Phone # to Precert: \_\_\_\_\_