COLUMBUS DIAGNOSTIC CENTER

Patient Demographics

Name:_____ DOB:_____ SS#:_____

Address:_____
PO Box or Street Address City State Zip Code

Phone Numbers: Home:_____ Cell:_____

Email Address:_____

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Primary Language: English / Spanish / Other:_____

Race: (please check all that apply)

❑White ❑Black or African American ❑Asian

❑American Indian or Alaska Native ❑Native Hawaiian or Other Pacific Islander

Ethnicity:

❑Hispanic or Latino ❑Not Hispanic or Latino

Employer Information

Company Name:_____ Work#:_____

Address:_____
Street Address City State Zip Code

Insurance Information

Primary Insurance

Insured Name:_____

DOB: _____

Secondary Insurance

Insured Name:_____

DOB: _____

Smoker: ____**Yes** ____**No**

Are you currently taking any medications? ____Yes ____No

If yes, please list the medications:

_____ _____

_____ _____

_____ _____

Please list any medications that you are allergic to:

_____ _____

_____ _____

_____ _____

Please list any person(s) that may have permission to have access to your information (i.e. pick up films/disk/report) or be used as an emergency contact

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone Number:_____ Phone Number:_____

Is your visit today related to an injury or accident? ❑Yes ❑No

(If yes please complete section below)

Injury due to: ❑Work ❑Auto ❑Trauma ❑Slip/Fall

Date of Injury:_____ Time of Injury:_____

Location of Injury: examples (home, skiing, walking, etc.)_____

What part of your body was injured?(be specific)_____

Have you been receiving treatment for this injury? ❑Yes ❑No

If yes, who is the doctor treating you for the injury?_____

Patient Signature X:_____ **Date:**_____