# PATIENT INFORMATION FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td></td>
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<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>Middle Name:</td>
<td></td>
</tr>
<tr>
<td>MRN:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Address 1:</td>
<td></td>
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<tr>
<td>Address 2:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Zip Code:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td></td>
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<tr>
<td>Cell Phone:</td>
<td></td>
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<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Preferred Contact Method:</td>
<td></td>
</tr>
<tr>
<td>Preferred Delivery Method:</td>
<td></td>
</tr>
<tr>
<td>Preferred Language:</td>
<td></td>
</tr>
<tr>
<td>Race:</td>
<td>American Indian / Alaska Native</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian / Other Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>White / Caucasian</td>
<td></td>
</tr>
<tr>
<td>Are you:</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Not Hispanic</td>
<td></td>
</tr>
<tr>
<td>Referring Physician:</td>
<td></td>
</tr>
</tbody>
</table>

## RESPONSIBLE PARTY INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>Patient’s Relationship to Responsible Party:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Address 1:</td>
<td></td>
</tr>
<tr>
<td>Address 2:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Zip Code:</td>
<td></td>
</tr>
</tbody>
</table>

### Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: [ ] YES [ ] NO
If Yes, whom?

Primary Insurance Name:            Plan Name:            
Address:                            
City:                                
State:                              
Zip:                                 
Policy #:                            
Policy Holder Name:                  
Policy Holder Address:               
City:                                
State:                              
Zip:                                 
Patient's Relationship to Policy Holder:

### Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: [ ] YES [ ] NO
If Yes, whom?

Primary Insurance Name:            Plan Name:            
Address:                            
City:                                
State:                              
Zip:                                 
Policy #:                            
Policy Holder Name:                  
Policy Holder Address:               
City:                                
State:                              
Zip:                                 
Patient's Relationship to Policy Holder:

## MEDICAL INFORMATION

Is this visit related to an auto accident? [ ] Yes [ ] No
Is this visit related to an injury sustained while at work? [ ] Yes [ ] No
Date of Injury: __________/_________/__________ Height: __________ ft. __________ in. Weight: __________

**SMOKING STATUS:**
- [ ] Current Every Day
- [ ] Current Some Days
- [ ] Never smoked
- [ ] Smoker, current status unknown
- [ ] Former smoker
- [ ] Unknown

**ACTIVE MEDICATIONS:**
- [ ] Actoplus Med
- [ ] Fortamet
- [ ] Glyburid Met
- [ ] Metaglip
- [ ] Avandamet
- [ ] Glucophage
- [ ] Glycomet
- [ ] Metformin
- [ ] DiaBex
- [ ] Glucovance
- [ ] Janumet
- [ ] PrandiMet
- [ ] Diafomin
- [ ] Glumetza
- [ ] Kombiglizexr
- [ ] Riomet (liquid form of Metformin)

**MEDICAL HISTORY:**
- [ ] None
- [ ] Aneurysm Clip / Coil
- [ ] Breast Implants
- [ ] Insulin Pump
- [ ] Paraplegic
- [ ] Aneurysm Had Surgery
- [ ] Cancer
- [ ] Metal In the Body
- [ ] Previous CT Contrast Reaction
- [ ] Aneurysm NO Surgery
- [ ] Diabetes
- [ ] Morphpine Pump
- [ ] Previous MR Contrast Reaction
- [ ] Asthma
- [ ] Hypertension
- [ ] Pacemaker
- [ ] Renal Disease

**ALLERGIES:**
- [ ] None
- [ ] Adhesive Tape
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Latex
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Bee Sting
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Lidocaine / Novacaine
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Betadine (Topical Iodine)
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Mold
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Contrast (Med. Imaging)
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Peanut or other nut
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Dog, Cat, or Animal
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Penicillin
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Dust
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Rubbing Alcohol
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Fruit
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Shellfish
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Grass / Pollen
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Shellfish
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
- [ ] Sulfa Drug
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe

*Mild allergic reactions* include hives, itching, nasal congestion, rash and watery eyes.

*Moderate allergic reactions* include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness.

*Severe allergic reaction* is anaphylactic shock.

**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**

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

**Signature of Patient, or Personal Representative**

**Date**