## PATIENT INFORMATION FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Last Name</td>
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<tr>
<td>First Name</td>
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<tr>
<td>Middle Name</td>
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<tr>
<td>MRN</td>
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<tr>
<td>DOB</td>
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<tr>
<td>Gender</td>
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<td>Address 2</td>
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<tr>
<td>City</td>
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<tr>
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<td>Zip Code</td>
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<tr>
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<td>Preferred Contact Method</td>
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<td>Preferred Delivery Method</td>
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<td>Preferred Language</td>
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<td>Race</td>
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<td>Hispanic</td>
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<td>Referring Physician</td>
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## RESPONSIBLE PARTY INFORMATION

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<td>Zip Code</td>
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### Primary Insurance Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>For Medicare Patients: Are You or Your Spouse Working?</td>
<td>☐ YES ☐ NO</td>
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<tr>
<td>Primary Insurance Name</td>
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</tr>
<tr>
<td>Address</td>
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<tr>
<td>Policy #</td>
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<tr>
<td>Policy Holder Name</td>
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<tr>
<td>Sex</td>
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<td>Policy Holder Address</td>
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### Secondary Insurance Information

<table>
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<th>Field</th>
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<td>For Medicare Patients: Are You or Your Spouse Working?</td>
<td>☐ YES ☐ NO</td>
</tr>
<tr>
<td>Primary Insurance Name</td>
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<td>Address</td>
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<td>Sex</td>
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<td>Policy Holder Address</td>
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### MEDICAL INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this visit related to an auto accident?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Is this visit related to an injury sustained while at work?</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>
**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
- [ ] Kombigluxe
- [ ] 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
- [ ] Morphine Pump
- [ ] Previous MR Contrast Reaction
- [ ] Asthma
- [ ] Hypertension
- [ ] Pacemaker
- [ ] Renal Disease

**ALLERGIES:**
- [ ] None
- [ ] Adhesive Tape
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Latex
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Mild
- [ ] Moderate
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- [ ] Moderate
- [ ] Severe
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] 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 anaphalytic 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.

---

**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