

Rolling Oaks Radiology Oxnard 1901 N. Rice Ave. Oxnard, CA 93030 Phone: (805) 604-3370 Fax: (805) 485-2541

PATIENT INFORMATION FORM

Last Name:		First Name:			Middle Name:							
MRN:		DOB:			Gender:							
Address 1:												
Address 2:												
City:	St	ate:			Zip Code:							
Home Phone:	Work Phone:		Cell Pho	ne:	Email:							
Preferred Contact Method:	□ Home Phone	Cell Phone	Work P		🗆 Email 🔹 Mail							
			Preferred Lang									
Preferred Delivery Method:				_								
Race: D American Indian / A	Alaska Native D Asian	Black or Af	rican American	□ Nativ	e Hawaiian / Other Pacific Islander	White / Caucasian						
Are you: Hispanic	Not Hispanic	Refer	rring Physician:									
RESPONSIBLE PARTY INFORMATION												
Last Name:		First Name:										
Patient's Relationship to Res	ponsible Party:				Phone:							
Address 1:												
Address 2:												
	01				7'r Order							
City:	518	ate:	ry Incuranco I	nformat	Zip Code:							
For Medicare Patients: Are	You or Your Spouse M		ry Insurance I	NO	If Yes, whom?							
Primary Insurance Name:		ionang i		110	Plan Name:							
Address:												
City:		State:			Zip:							
Policy #:		DOB:										
Policy Holder Name:					Sex:							
Policy Holder Address:												
City:		State:			Zip:							
Patient's Relationship to Poli	cy Holder:											
Secondary Insurance Information												
For Medicare Patients: Are	You or Your Spouse W	/orking?:	□ YES □	NO	If Yes, whom?							
Primary Insurance Name:					Plan Name:							
Address:												
City:		State:			Zip:							
Policy #:		Group #:			DOB:							
Policy Holder Name:					Sex:							
Policy Holder Address:												
City:		State:			Zip:							
Patient's Relationship to Poli	cy Holder:											

Date of Service:

MRN:

Is this visit related to an au	□ Yes	🗆 No											
Is this visit related to an inj	□ Yes	🗆 No											
Date of Injury:	/	/		Height:	_ ft	in.	Weight:						
SMOKING STATUS:													
Current Every Day	Current Some I	Days □ Ne\	ver smoked	Smoker, current status unkno	wn 🗆 Fo	rmer smoker	Unknown						
ACTIVE MEDICATIONS: IN None													
□ ActoPlus Med		ortamet		Glyburid Met	Glyburid Met Glyburid Met								
□ Avandamet	□G	ilucophage		Glycomet		Metformin							
□ Diabex	□G	lucovance		□ Janumet		PrandiMet							
Diafomin	□G	lumetza		□ Kombiglzexr		□ Riomet (liquid form of Metf							
MEDICAL HISTORY:	□ None												
Aneurysm Clip / Coil	ΠB	reast Implants		Insulin Pump		Parplegic							
Aneurysm Had Surgery	<i>ı</i> □C	ancer		Metal In the Body		Previous CT Contrast Reaction							
Aneurysm NO Surgery		iabetes		□ Morphine Pump		Previous MR Contrast Reaction							
□ Asthma	DH	ypertension		Pacemaker		Renal Disease							
ALLERGIES: D None	;												
□ Adhesive Tape	□ Mild	□ Moderate	□ Severe	□ Latex	D Mild	□ Modera	ate 🛛 Sever	re					
□ Bee Sting	□ Mild	□ Moderate	□ Severe	Lidocaine / Novacaine	D Mild	□ Modera	ate 🛛 Sever	re					
□ Betadine (Topical Iodine	e) 🗆 Mild	□ Moderate	□ Severe	□ Mold	D Mild	□ Modera	ate 🗆 Sever	re					
Contrast (Med. Imaging) 🗆 Mild	□ Moderate	□ Severe	Peanut or other nut	□ Mild	□ Modera	ate 🛛 Sever	re					
Dog, Cat, or Animal	□ Mild	□ Moderate	□ Severe	Penicillin	□ Mild	□ Modera	ate	re					
Dust	D Mild	□ Moderate	□ Severe	Rubbing Alcohol	□ Mild	□ Modera	ate 🛛 Sever	re					
Fruit	□ Mild	□ Moderate	□ Severe	□ Shellfish	□ Mild	□ Modera	ate	re					
Grass / Pollen	D Mild	□ Moderate	□ Severe	Sulfa Drug	□ Mild	□ Modera	ate 🗆 Sever	re					
Mild allergie reactions in	oludo hivoo itohin		tion roch and y	votory ovos									

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, vomitting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconciousness.

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.

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