



MDI - Westlake Xray  
1240 S. Westlake Blvd. Suite 111  
Westlake Village, CA 91361  
Phone: (805) 449-2562  
Fax: (805) 445-2581

### PATIENT INFORMATION FORM

Last Name:	First Name:	Middle Name:			
MRN:	DOB:	Gender:			
Address 1:					
Address 2:					
City:	State:	Zip Code:			
Home Phone:	Work Phone:	Cell Phone:	Email:		
Preferred Contact Method:	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Email	<input type="checkbox"/> Mail
Preferred Delivery Method:	<input type="checkbox"/> Mail	<input type="checkbox"/> Electronic	Preferred Language:		
Race:	<input type="checkbox"/> American Indian / Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian / Other Pacific Islander	<input type="checkbox"/> White / Caucasian
Are you:	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Not Hispanic	Referring Physician:	_____	

### RESPONSIBLE PARTY INFORMATION

Last Name:	First Name:	
Patient's Relationship to Responsible Party:	Phone:	
Address 1:		
Address 2:		
City:	State:	Zip Code:

### Primary Insurance Information

<b>For Medicare Patients: Are You or Your Spouse Working?:</b>	<input type="checkbox"/> YES	<input type="checkbox"/> 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 Policy Holder:			

### Secondary Insurance Information

<b>For Medicare Patients: Are You or Your Spouse Working?:</b>	<input type="checkbox"/> YES	<input type="checkbox"/> 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 Policy Holder:			

Patient:                      DOB:                      MRN:                      Date of Service:

**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:  None**

ActoPlus Med  Fortamet  Glyburid Met  Metaglip  
 Avandamet  Glucophage  Glycomet  Metformin  
 Diabex  Glucovance  Janumet  PrandiMet  
 Diafomin  Glumetza  Kombiglzex  Riomet (liquid form of Metformin)

**MEDICAL HISTORY:  None**

Aneurysm Clip / Coil  Breast Implants  Insulin Pump  Parplegic  
 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**

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Latex	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Bee Sting	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Lidocaine / Novacaine	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Betadine (Topical Iodine)	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Mold	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Contrast (Med. Imaging)	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Peanut or other nut	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Dog, Cat, or Animal	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Dust	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Rubbing Alcohol	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Fruit	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Grass / Pollen	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Sulfa Drug	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> 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.

\_\_\_\_\_  
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

Patient:            DOB:            MRN:            Date of Service: