

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

| | | | |
|---|--|----------|---------------|
| For Medicare Patients: Are You or Your Spouse Working?: <input type="checkbox"/> YES <input type="checkbox"/> NO | | | If Yes, whom? |
| Primary Insurance Name: | | | Plan Name: |
| Address: | | | |
| City: | | State: | |
| Zip: | | | |
| Policy #: | | Group #: | |
| DOB: | | | Sex: |
| 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?: <input type="checkbox"/> YES <input type="checkbox"/> NO | | | If Yes, whom? |
| Primary Insurance Name: | | | Plan Name: |
| Address: | | | |
| City: | | State: | |
| Zip: | | | |
| Policy #: | | Group #: | |
| DOB: | | | Sex: |
| 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is this visit related to an injury sustained while at work? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient: DOB: MRN: Date of Service:

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

| | | | |
|---------------------------------------|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> ActoPlus Med | <input type="checkbox"/> Fortamet | <input type="checkbox"/> Glyburid Met | <input type="checkbox"/> Metaglip |
| <input type="checkbox"/> Avandamet | <input type="checkbox"/> Glucophage | <input type="checkbox"/> Glycomet | <input type="checkbox"/> Metformin |
| <input type="checkbox"/> Diabex | <input type="checkbox"/> Glucovance | <input type="checkbox"/> Janumet | <input type="checkbox"/> PrandiMet |
| <input type="checkbox"/> Diafomin | <input type="checkbox"/> Glumetza | <input type="checkbox"/> Kombiglzexr | <input type="checkbox"/> Riomet (liquid form of Metformin) |

MEDICAL HISTORY: None

| | | | |
|--|--|--|--|
| <input type="checkbox"/> Aneurysm Clip / Coil | <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Insulin Pump | <input type="checkbox"/> Parplegic |
| <input type="checkbox"/> Aneurysm Had Surgery | <input type="checkbox"/> Cancer | <input type="checkbox"/> Metal In the Body | <input type="checkbox"/> Previous CT Contrast Reaction |
| <input type="checkbox"/> Aneurysm NO Surgery | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Morphine Pump | <input type="checkbox"/> Previous MR Contrast Reaction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> 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: