

**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:			

**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 <b>Had Surgery</b>	<input type="checkbox"/> Cancer	<input type="checkbox"/> Metal In the Body	<input type="checkbox"/> Previous CT Contrast Reaction
<input type="checkbox"/> Aneurysm <b>NO Surgery</b>	<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:**