Healthcare Imaging Center
A RadNet Imaging Center

Healthcare Imaging at Day Street
6485 Day Street Suite 101
Riverside, CA 92507
Phone: (951) 200-5410
Fax: (951) 656-6068

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: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Delivery Method: ☐ Mail ☐ Electronic Preferred Language:

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian

Are you: ☐ Hispanic ☐ 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?: ☐ 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 Policy Holder:

Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ 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 Policy Holder:

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	☐ Kombiglzexr	☐ 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

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