RadNet Medical Imaging San Francisco

A RadNet Imaging Center

PATIENT INFORMATION FORM

Last Name:		First Name:				Middle Name:		
MRN:		DOB:				Gender:		
Address 1:								
Address 2:								
City:	St	ate:				Zip Code:		
		ale.	0.11					
Home Phone:	Work Phone:			Phone:		Email:		
Preferred Contact Method:	□ Home Phone	Cell Phone	U Work P	hone	🗆 Email	Mail		
Preferred Delivery Method:	Mail Electronic		Preferred Lang	luage:				
Race: 🛛 American Indian / A	laska Native DAsian	□ Black or Afr	ican American	□ Nativ	e Hawaiian / (Other Pacific Islander	□ White / Caucasia	n
Are you: 🗆 Hispanic 🛛 🗅	Not Hispanic	Refer	ring Physician:					
		RESPONS	IBLE PARTY	INFORM	ATION			
Last Name:		First Name:						
Patient's Relationship to Resp	oonsible Party:					Phone:		
Address 1:								
Address 2:								
	Sta	to:				Zin Codo:		
City:	518		y Insurance I	nformat	lion	Zip Code:		
For Medicare Patients: Are	You or Your Spouse W			NO		If Yes, whom?		
Primary Insurance Name:		5	-	-		Plan Name:		
Address:								
City:		State:				Zip:		
Policy #:		Group #:				DOB:		
Policy Holder Name:						Sex:		
Policy Holder Address:								
City:		State:				Zip:		
Patient's Relationship to Polic	cy Holder:							
		Seconda	ary Insurance	Inform	ation			
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 Polic	cy Holder:							
		MED	DICAL INFOR	MATION	1			
Is this visit related to an auto	accident?						□ Yes	□ No
Is this visit related to an injury	sustained while at work	?					□ Yes	□ No

MRN:

DOB:

Date of Injury:	/	/		Height:	ft		in.	Weight:	
SMOKING STATUS:									
Current Every Day	Current Some	Days 🛛 Nev	er smoked	☐ Smoker, current status unkn	iown	□ Forme	er smoker	Unknown	
ACTIVE MEDICATIONS:	□ None								
□ ActoPlus Med	Fortamet			Glyburid Met		Metaglip			
□ Avandamet	□ Glucophage			□ Glycomet	Metformin				
□ Diabex	Glucovance			□ Janumet	□ Janumet				
Diafomin	□G	lumetza		□ Kombiglzexr		Riomet (liquid form of Metformir			
MEDICAL HISTORY:	None								
Aneurysm Clip / Coil	D B	reast Implants		Insulin Pump	Parplegic				
Aneurysm Had Surgery	□C	ancer		□ Metal In the Body		Previous CT Contrast Reaction			
Aneurysm NO Surgery	□ Diabetes			□ Morphine Pump		Previous MR Contrast Reaction			
□ Asthma	Hypertension			Pacemaker		🗆 Re			
ALLERGIES: INone									
□ Adhesive Tape	□ Mild	□ Moderate	□ Severe	□ Latex		⊐ Mild	Moderat	e 🛛 Severe	
□ Bee Sting	□ Mild	□ Moderate	□ Severe	Lidocaine / Novacaine	0	⊐ Mild	☐ Moderat	e 🛛 Severe	
□ Betadine (Topical lodine)	□ Mild	□ Moderate	□ Severe	□ Mold	6	∃ Mild	□ Moderat	e 🛛 Severe	
Contrast (Med. Imaging)	□ Mild	□ Moderate	□ Severe	Peanut or other nut	C	∃ Mild	□ Moderat	e 🛛 Severe	
Dog, Cat, or Animal	□ Mild	□ Moderate	□ Severe	Penicillin	6	∃ Mild	□ Moderat	e 🛛 Severe	
Dust	□ Mild	□ Moderate	□ Severe	□ Rubbing Alcohol	0	∃ Mild	□ Moderat	e 🛛 Severe	
Fruit	□ Mild	□ Moderate	□ Severe	□ Shellfish	0	⊐ Mild	□ Moderat	e 🛛 Severe	
Grass / Pollen	□ Mild	□ Moderate	□ Severe	□ Sulfa Drug	[⊐ Mild	☐ Moderat	e 🛛 Severe	
Mild allergic reactions includ Moderate allergic reactions i	include cramp	s, chest tightnes	s, diarrhea, diffic			ziness, lię	ght headedne	ess, flushing/redness	

of face, nausea, vomitting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconciousness. Severe allergic reaction is anaphalytic shock.

anergie 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 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

Date

Patient: DOB: MRN:

2 of 2