

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:			
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?: <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

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