Location Name:	Date:	MRN/Jacket:	**Patient Registration**

Name: _____
Address: _____
Home: _____ **Work:** _____ **Mobile:** _____
Email: _____ **Date of Birth:** _____
Race: _____ **Gender:** _____ **Marital Status:** _____
SSN: _____ **Employer:** _____
Registered Location: _____ **Physician**: _____

Emergency Contact Information

Name: _____ **Relationship to Patient:** _____
Address: _____
Home: _____ **Work:** _____ **Mobile:** _____

Insurance

Primary Insurance Plan Name: _____
Policy #: _____ **Group Name:** _____ **Group #:** _____
Secondary Insurance Plan Name: _____
Policy #: _____ **Group Name:** _____ **Group #:** _____

Relationship to Insured Other than Self

Name: _____ **Relationship to Patient:** _____
Address: _____
Home: _____ **Work:** _____ **DOB:** _____
Employment Status: _____ **Employer:** _____

Auto Accident or Worker's Compensation Information

Is this injury due to accident? **Yes** ☐ **No** ☐ **If yes, what type of Accident?** _____
Accident Date: _____ **Accident State:** _____
Auto Insur Info: _____ **Phone:** _____
Auto Insur Adrs: _____ **City:** _____ **State:** _____ **Zip:** _____
Case Manager or Adjuster's Name: _____ **Phone:** _____

MRN/Jacket #: _____

By signing below, I agree to the following for outpatient radiology care provided by _____

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, _____ may use and disclose my protected health information for treatment, payment and health care operations as explained in the_____ Notice of Privacy Practices. I also authorize release of my protected health information to _____ the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Financial Responsibility

With this consent, I authorize _____ and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to _____ on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent_____ may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that _____ has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it _____ may decline to provide treatment to me.

Signature: _____ Date: _____

Printed Name: _____

If you would like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship below.

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Location Name:	Date:	MRN/Jacket #:	PATIENT HISTORY FORM

Patient Name: _____ Gender: _____ DOB: _____ Age: ____

Height: _____ Feet ___ Inches Current Weight: _____ lbs

Referring Physician: _____ Procedure: _____

Reason you are here today for an exam? Explain your medical problem in detail.

_____

Have you had a previous imaging study related to this problem (x-ray, ultrasound, CT, MRI)? ☐ **Yes** ☐ **No**

If yes, please explain: What exam? _____

When? _____ Name of facility: _____

List any drug or food allergies: _____

List previous surgeries: _____

Medications you are presently taking: _____

Any other medical issues we should know about: _____

Female Patients Only

Is there any chance you may be pregnant? ☐ **Yes** ☐ **No** **Date of last period:** _____

Are you breastfeeding? ☐ **Yes** ☐ **No**

For Contrast Exams Only ***For Contrast Exams Only***

Have you ever had a previous allergic reaction to injected contrast during a CT, MRI, or X-Ray? ☐ **Yes** ☐ **No**

If yes, explain:

Any Personal History of:

☐ **Yes** ☐ **No**	Seizure Disorder	☐ **Yes** ☐ **No**	Heart Disease
☐ **Yes** ☐ **No**	Stroke	☐ **Yes** ☐ **No**	High Blood Pressure
☐ **Yes** ☐ **No**	Asthma	☐ **Yes** ☐ **No**	Blood Disorder/Sickle Cell
☐ **Yes** ☐ **No**	Liver Disease	☐ **Yes** ☐ **No**	Kidney Disease/Kidney Failure
☐ **Yes** ☐ **No**	Multiple Myeloma	☐ **Yes** ☐ **No**	Dialysis
☐ **Yes** ☐ **No**	Cancer If yes, please specify	_____	

Are you diabetic? ☐ **Yes** ☐ **No**

Are you taking Metformin hydrochloride (Glucophage, Glucovance, Avandement, Metaglip, and Fortamet)? ☐ **Yes** ☐ **No**

Patients with Diabetes

If you are taking Metformin (Glucophage, Glucovance, etc.) and having a contrast injection in X-ray or CT today, you will be asked to stop taking it for 48 hours post injection of contrast media. Contact your primary physician prior to restarting your Metformin to make sure your renal functions are okay.

I will stop my Metformin and contact my physician before restarting it. _____ **(Initial Here)**

Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me.

I give consent to the performance of a/an _____

Patient/Parent/Guardian Signature: _____ **Date:** _____

Jacket/MRN# _____ ***Technologist Clinical Worksheet***

Name: _____ **DOB: _____** **Age: ___**

Appointment: _____ **Gender_____ Weight: _____lbs. Height:_____**

Accession#	**Exam**	**Tech Name:** **Notes:**

******************PREVIOUS EXAM HISTORY*****************

Ref Physician: _____ **Ref Physician Follow Up:**

Ref. Phys. Phone: _____ **Ref. Phys. Fax: _____**

Reason for Exam _____

Signs and Symptoms: _____

How long? _____ **History of Trauma:** Yes No

Surgeries? _____

Tech Notes: _____

_____

Are Outside Studies Available? Yes No Images? Yes No Outside Reports Scanned? Yes No

Date of Labs: _____ I-STAT used: Yes No Creatinine _____ mg/dl eGER ___ ml/min

CONTRAST ADMINISTRATION **Types of Contrast: Oral IV Both**

Volume/Name: _____cc of _____ Lot#_____ Exp. Date_____

Power injector used? Yes No Flow Rate:_____ cc/sec

IV INFORMATION

Size:_____ g IV Location: R L _____ # of Attempts_____ DC'd intact? Yes No

Discharge Instructions Given? Yes No Patient Education Given? Yes No

Special Instructions:_____