

Today's Date:		Sex: Male Female	
Name: (Last)		(First)	
Height:	Weight:	Age:	Race:
List Medications:			
Are you postmenopausal?		Yes or No	
- If yes, when did you start menopause:			
Have you ever fractured your hip?		Yes or No	
- If yes, when:			
Have you ever fractured your spine?		Yes or No	
- If yes, when:			
Have you ever fractured your wrist?		Yes or No	
- If yes, when:			
Have you fractured any other bone since age 50?		Yes or No	
- If yes, what bone(s):			
Do you have a family history of osteoporosis?		Yes or No	
Do you smoke tobacco?		Yes or No	
Do you drink alcohol?		Yes or No	
Do you exercise?		Yes or No	
If you are a premenopausal woman, do you have regular periods?		Yes or No	
Do you take Estrogen and/or Progesterone medications?		Yes or No	
Do you take Alendronate (Fosamax), Calcitonin, Prednisone or other steroids?		Yes or No	
- If yes, please circle which one and for how long?			
Have you ever had surgery on your hip, spine or wrist?		Yes or No	
- If yes, which bone and when?			
Have you lost more than 2 inches in height since high school?		Yes or No	
Are you pregnant?		Yes or No	

Signature _____



PATIENT INFORMATION

MRN#

Name

DOB

Address

City, State, Zip

Social Security #

Home Phone #

**Work/ Mobile
Phone#**

Email Address

Policy Holder

Relationship

Guarantor DOB

UPDATED INFORMATION

SCHEDULED EXAM:

Ref. Physician _____

Ref. Physician Phone _____

Additional Physicians:

Physician / Phone # _____

I understand that I am responsible for my bill and any charges or charge balances not paid by my insurance. I understand that there will be a fee of \$35.00 for any checks returned for insufficient funds. I authorize payment direct to my physician. I authorize use of all medical information to process this claim. I authorize the qualified medical personnel of this facility to perform this procedure.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE



MEANINGFUL USE FORM

PATIENT NAME:

DOB:

MRN:

Meaningful Use Defined:

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Meaningful use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

Ethnicity: Hispanic or Latino Not Hispanic or Latino Preferred Language: _____

Please indicate any Family Health History -

Mother _____ Father _____

Sister _____ Brother _____

Race: (Please check one)

American Indian or Alaska Native Asian Black or African American Caucasian

Pacific Islander or Native Hawaiian Other

Smoking Status: (Please check one)

Current everyday Current some day smoker Former smoker Never smoker Unknown

Height:

Weight :

Blood Pressure: _____

Please list any known allergies (Include reaction):

Please list your current medications :



PATIENT RIGHTS AND AUTHORIZATION

PATIENT NAME:

DOS:

MRN:

A. Patient Rights: Please check the appropriate box below:

- I have been informed of my patient rights.
- I have been offered a written copy of my patient rights

B. Authorization to Release Medical Information to Family Members/Friends:

I give permission to Imaging Specialists to release information regarding appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number, healthcare information, and treatment to the following individuals:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

PLEASE CHECK HERE IF YOU DO NOT WISH TO LIST ANYONE

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

PRINT NAME OF ABOVE SIGNATURE