Imaging Specialists

PATIENT INFORMATION	UPDATED INFORMATION
MRN#	
Name	
DOB	
Address	
City, State, Zip	
Social Security #	
Home Phone #	
Work/ Mobile Phone#	
Email Address	
Policy Holder	
Relationship	
Guarantor DOB	

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 REPRESENATIVE DATE

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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 :

_____

_____

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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 REPRESENATIVE DATE

_____

PRINT NAME OF ABOVE SIGNATURE

CT HISTORY FORM

Patient Name:_____ **Age:**_____ **NPO:** YES NO

Reason for exam:_____

As part of the test requested by your doctor, contrast media (xray dye) may be injected through a vein. This will allow our Radiologist to better visualize certain areas of your anatomy being scanned. Please answer the following questions:

CONTRAST AMOUNT: NON-CONTRAST CONTRAST-100cc OMNIPAQUE 350

Have you had CT/XRAY Contrast before? YES NO **If YES, list any allergy/reaction:**_____

Have you had any allergies to any drugs, iodine, tape, latex, or foods? Please list:_____

_____

Do you have asthma or environmental allergies? YES NO

Could you be pregnant? YES NO **LMP?**_____ **Currently breastfeeding?** YES NO

Do you have high blood pressure or a heart condition? YES NO

Are you taking diuretics (water pills)? YES NO

Do you regularly take ibuprofen (Motrin, Advil, Naprosyn, Aleve, or any other non-steroidal anti-inflammatory drug)? YES NO

Kidney problems? YES NO **On Dialysis?** YES NO **Renal transplant?** YES NO

Diabetes? YES NO **Requiring oral medication or insulin?** YES NO

Patient taking: Glucophage, Metformin, Avandamet, Glucovance, or Metaglib.

Creatinine:_____ **Date:**_____

Prior Surgeries: Breast, Lung, Heart, Gallbladder, Appendectomy, Small Bowel, Large bowel, Kidney, Prostate, Hysterectomy, Brain, Spine, Sinus. **Other:**_____

History of : Multiple Myeloma, Asthma, Lupus, Sickle cell disease, Collagen vascular disease, Pheochrmocytoma

History of Cancer: YES NO **What type?**_____

Have you had Chemotherapy? YES NO **Radiation?** YES NO

PATIENT ACKNOWLEDGEMENT:

I have received, read, and understand the information contained on this form. I have had the opportunity to ask questions if I have any and received an adequate explanation.

Signature:_____ **Date:**_____

Tech initials:_____ **IV started:**_____ **History:**_____