PATIENT REGISTRATION INFORMATION

Today's Date: ____/____/____ Referring Physician: _____

Patient Information

Last name: _____ First name: _____ Middle Initial: ____

Social Security # _____ Sex: Male ( ) Female ( ) Date of Birth: ____/____/____

Address: _____ Apt # _____

City, State, ZIP Code: _____

Home Phone # _____ Alt. /Cell # _____

Emergency Contact: Name _____ Relationship_____

Home Phone # _____ Alt. /Cell # _____

Patient's Employment: Full Time___ Part Time ____ Retired ____ Not Employed ____ Student____

Employer: _____ Work phone # _____

Address: _____

Primary Insured: _____ Self (Skip to Primary Insurance Section)

Name & Relationship to Patient: _____ Date of Birth: ___/____/____

Primary Insurance: _____

Policy # _____ Group # _____

Secondary Insurance: _____

Policy # _____ Group # _____

2003–A Whitesburg Drive, Huntsville, AL 35801 –Phone (256) 536-3550 Fax (256) 536-3554

THE CENTER OF IMAGING EXCELLENCE

Cat Scan Screening Sheet

Why did your Doctor order the exam we are doing today?

_____

If you have pain; where do you hurt?

_____

If you have pain; how long have you hurt there? _____ DAYS / WEEKS / MONTHS / YEARS

If you have pain; was it caused by a trauma? (Hurt it? Car wreck? Fall?) **YES NO**

Explain. _____

Have you had any of these removed? (Circle YES if applicable)

Kidney Removed?	YES	Removed due to cancer?	YES / NO	Chemo? Radiation?
Uterus Removed?	YES	Removed due to cancer?	YES / NO	Chemo? Radiation?
Ovaries Removed?	YES	Removed due to cancer?	YES / NO	Chemo? Radiation?
Thyroid Gland Removed?	YES	Removed due to cancer?	YES / NO	Chemo? Radiation?
Appendix Removed?	YES			
Gall Bladder Removed?	YES			

Other Surgeries or Cancer? If you have had cancer...Did you have Chemo, Radiation, or Surgery? Due to that Cancer?

_____

Previous CT or MRI exams **of the area we are scanning**?(Only exams of same area are relevant for comparison)

List Exam, Where and When it was completed_____

Revised 2/15/17 gan

PATIENT AGREEMENT AND ACKNOWLEDGEMENT FORM

I understand payment of all insurance benefits for this period of service must be made directly to The Center of Imaging Excellence. If a check must be made out to me, I understand that the check must be sent to The Center of Imaging Excellence at the address listed at the bottom of this page.

Initial _____

I understand The Center of Imaging Excellence must collect for all the charges not covered by insurance payment. Payment for all collection costs is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

Initial _____

I hereby consent to The Center of Imaging Excellence to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetics as necessary and any other general medical/emergency treatment and hospital care considered advisable or necessary by the physician.

Initial _____

Acknowledgement to use and disclose health information for treatment, payment, or healthcare operations (HIPAA pamphlet available on the front desk counter). I understand and have been offered a copy of the Privacy Practices of The Center of Imaging Excellence.

Initial _____

I have read and do understand the above statements and I have willingly signed.

_____ _____

Signature of the Patient / Guardian Date

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