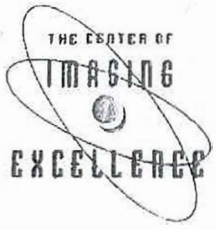


PATIENT REGISTRATION INFORMATION

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

Ultrasound Patient Screening Form

Your Ultrasound Technologist will answer any questions about this form when they take you to your room.

What problem were you sent for this exam today? _____

How long have you had this problem? _____

Any previous imaging **of the area we are scanning today**? If Yes, Where was it done and When?

MRI: _____

CT: _____

Other: _____

Are you a current smoker? Yes No

Have you been a smoker previously? Yes No

Are you allergic to anything? Yes No

If yes, What are your allergies? _____

Have you had any problems with your kidneys or been in Renal Failure? Yes No

If you are diabetic, what medications do you take for diabetes? _____

Have you ever had surgery on the area we are scanning today? Yes No

If yes, What kind and When? _____

For Female patients (Age 12-55): Are you pregnant? Yes No

What is the date of your last menstrual period: _____

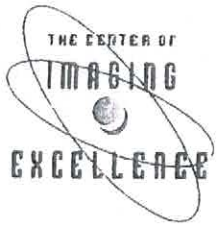
Have you had a hysterectomy? Yes No

If Yes, did they remove your ovaries as well? Yes No

I have answered all of these questions to the best of my knowledge and understand the information given.

Patient Signature: X_____ Technologist Signature: _____

Revised: 10/17/2019 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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