

ZWANGER-PESIRI RADIOLOGY

PATIENT REGISTRATION FORM

Today's Date:

Last Name	First Name	MI	Date of Birth	Male	Female
Street Address				Height	Weight
City	Zip Code	Preferred Email Address			
Social Security #	Home Phone	Work Phone	Cell Phone		
Employer Name					
Insured's Name		Insured's Employer		Relationship to Patient	
Insurance		ID#		Insured's DOB	
Secondary Insurance		Secondary ID#		Secondary Insured's DOB	

Are you here as the result of a car accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you here as a result of a work related accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Does your insurance company have a deductible?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have an HSA or HRA plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, we need a copy of your debit card.</i>			

<p>Authorization of Treatment: I hereby consent to treatment by the radiologist and other medical staff for all local anesthetics, radiologic tests and/or procedures as deemed necessary by myself and the Zwanger-Pesiri Radiology staff.</p> <p>I am aware that additional charges may be incurred if a diagnostic mammogram is deemed necessary. I understand that according to my particular insurance plan, this may or may not be covered.</p>
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Authorization for Release of Information and Assignment of Benefits: I hereby assign to Zwanger-Pesiri Radiology, LLP those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with testing performed and treatment rendered. I request that payment of authorized benefits be made directly to Zwanger-Pesiri Radiology on my behalf. I fully understand that I am financially responsible for **any** and **all** amounts not otherwise paid by my insurance carrier:

I certify that the information on this form given by me for payment under Title XVIII(Medicare) is correct and complete. I authorize holder of medical or related information about me to be released to the Health Care Financial Administration (HCFA) and/or other health care coverage entity, any information needed of this or any related healthcare claim in writing or verbally. I further understand and agree to pay for services or amounts due when denied as not covered by Medicare or any other health insurance plans

I hereby authorize release of my films, images, reports and medical records as needed for subsequent medical care. In event of positive findings I authorize release of my results to my referring and treating physicians for their records.

I acknowledge that I have been provided with a copy of the Zwanger-Pesiri Radiology's Notice of Privacy Practices. In addition, I give the right for Zwanger-Pesiri Radiology, LLP to contact the following person(s) to discuss medical treatment and/or billing information:

Persons(s)	Relationship	Phone#
_____	_____	_____
_____	_____	_____

This authorization will remain in effect unless changed by me, while I am a patient of Zwanger-Pesiri Radiology, LLP.

Patient or Legal Guardian Signature: _____ Date: _____

Pregnancy Denial Statement

Women age 12-55 (Except Ultrasound)

I hereby attest that there is NO possibility that I am pregnant.

Patient's signature

Please list any physicians you would like to receive your report.

Physician

Office Address

_____	_____
_____	_____
_____	_____

ZWANGER-PESIRI

RADIOLOGY

X-Ray Questionnaire

Name of Patient _____ Date _____

All Patients

Reason for this X-ray, list symptoms: _____

Yes/No Have you had this X-ray before? If yes, where and when? _____

Yes/No Have you had any surgery? If yes, list type and date: _____

Yes/No Do you have any medical conditions? If yes, list and describe treatment : _____

Yes/No Do you have any abnormal lumps or masses? Where? _____

Chest Xray Patients Only

Yes/No Do you currently smoke? If yes, how many packs per day? _____

Yes/No Are you an ex-smoker? If yes, how long ago did you quit? _____

Yes/No Do you have any lung disease? Please describe: _____

Yes/No Do you have a cough? How long? _____

Yes/No Do you have any fever or infection? Please describe: _____

Yes/No Do you currently have asthma or wheezing ? _____

Yes/No Do you have any heart disease? What type? _____

Cancer Patients Only

Yes/No Do you currently have cancer? If yes, what type and treatment? _____

Yes/No Did you previously have cancer? If yes, what type and treatment? _____

Yes/No Have you had radiation therapy? If yes, list body part: _____

Yes/No Have you had chemotherapy? If yes, list date of last treatment: _____

Pain and Injury Patients Only

Yes/No Have you had any recent injury? When and what type? _____

Yes/No Do you have any tenderness to touch? Where? _____

Yes/No Do you have any pain? Where? _____

Yes/No Have you had any surgery? If yes, list type and date: _____