ZWANGER-PESIRI RADIOLOGY

PATIENT REGISTRATION FORM

CT

Page 1

Appointment 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#	
Secondary Insurance	Secondary ID#	Secondary Insured's DOB

	Yes	No
Are you here as the result of a car accident?	☐	☐
Are you here as the result of a work related	☐	☐

Why did you choose Zwanger-Pesiri Radiology?

A) Friend/Family Member Recommendation

B) Doctor Referral

C) Advertisement (Radio, Newspaper, Etc.)

D) Convenience (Hours, location, etc.)

ZWANGER-PESIRI RADIOLOGY

PATIENT REGISTRATION FORM

CT Page 2

Patient Name ______________________________ Date ______________

	Yes	No
Does your insurance have a deductible?	☐	☐
Do you have an HSA or HRA plan? If yes, we need a copy of your debit card.	☐	☐

Authorization for 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:

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.

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.

Pregnancy Denial Statement

Women age 12-55 (except ultrasound)
I hereby attest that there is **NO** possibility that I am pregnant.

____

Patient signature

ZWANGER-PESIRI RADIOLOGY

PATIENT REGISTRATION FORM

CT Page 3

Patient Name ____ Date _______________

CT Questionnaire

All CT Patients

Reason for this test, give symptoms: ____________________________________

Yes/No Have you had a CT scan before? If yes, where and when? ______________________________

Yes/No Are you allergic to CT scan IV contrast ? If yes, what was your reaction?

____

Yes/No Do you *currently* have asthma? If yes, list symptoms and medications:

____

Yes/No Are you diabetic? If yes, list current medications:_______________________

Yes/No Are you taking glucophage, metformin, glucovance, avandament, fortamet?

Yes/No Do you have any history of kidney failure? If yes, when? ________________

Yes/No Have you had blood tests (BUN, creatinine) in the last 2 months? Results?

____

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 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:____________

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

Yes/No Recent abnormal blood tests? List type and results: ____________________

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 Do you have a cough? If yes how long? ______________________________

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

Yes/No Have you ever smoked? If yes for how long?_________ How many packs a day?___________

If you are an ex-smoker, how long ago did you quit? _______________

Yes/No Do you take a medication called Hydroxyurea?

Coronary CTA scan Patients Only

Yes/No	Heart Attack	Yes/No	Heart Valve Problems
Yes/No	Stroke	Yes/No	Diabetes
Yes/No	Congestive Heart Failure	Yes/No	Heart Muscle problems
Yes/No	Heart Rhythm problems	Yes/No	Chest Pain
Yes/No	Pacemaker?Defibriallator	Yes/No	Hypertension
Yes/No	Shortness of breath with exercise?	Yes/No	Lung Disease
Yes/No	Chest discomfort or pain with exercise?	Yes/No	Asthma or wheezing
Yes/No	Do you use inhalers or bronchodilators?	Yes/No	Did you bring them?

Yes/No Angiogram/Cardiac Catheterization When? _____________________

Yes/No Angioplasty/Stent placement? When? ____________________

Yes/No Electrophysiology Studies/Ablation? When? ____________________

Yes/No Coronary Artery Bypass Surgery? When? ______________________

Yes/No Valve replacement surgery? When? Type? __________ ___________

Consent for IV Contrast Material: If your physician has requested or if the radiologist feels your condition/findings warrant, you may receive IV contrast material. **All Metformin patients please hold medications for next 48 hours**. The contrast is injected through a small needle placed in a vein in your arm or hand, much the same manner as when blood is drawn for laboratory studies. Occasionally a patient may have a mild reaction to the contrast agent and will develop sneezing or hives. Other or more severe reactions may occur but are uncommon. I understand this and give consent for the use of contrast during my CT scan. All my questions regarding contrast and potential reactions have been answered to my satisfaction.

____ __________

Signature of patient /parent/guardian ***Date***

ZWANGER-PESIRI RADIOLOGY

PATIENT REGISTRATION FORM

CT

Patient Name ____________________________________ **Date** ______________

Please sign here

I understand that payment is due at the time of service and that I am financially responsible for **ANY** and **ALL** amounts not otherwise paid by my insurance carrier.

I UNDERSTAND THAT MY ACCOUNT WILL BE SUBJECT TO AN ADDITIONAL $15.00 PROCESSING FEE EACH MONTH IF PAYMENT IS NOT RECEIVED BY THE DUE DATE INDICATED ON MY BILLING STATEMENT.

I further attest that the information I have provided on these ***forms*** are true to the best of my knowledge

____

Patient or Legal Guardian Signature ***Date***