

# ZWANGER-PESIRI RADIOLOGY

## PATIENT REGISTRATION FORM

**X-Ray** 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	

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

**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.)

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#

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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**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**X-Ray Questionnaire**

**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: \_\_\_\_\_

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*