PrecisionImaging
Dedicated to Diagnostic Excellence

PATIENT INFORMATION

NAME: LAST, FIRST MI	SOC SEC NUMBER:	DATE OF BIRTH:	SEX: M ☐ F ☐

ADDRESS:	Home Phone:
	Work Phone:
CITY/STATE/ZIP:	Cell Phone:
Employer:	EMAIL:

Preferred Notification Method (select one): ☐ EMAIL ☐ MAIL ☐ CALL HOME ☐ CALL CELL ☐ CALL WORK

Guarantor/Individual Responsible for Bill:

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Name:		Insurance Name:	
ID#	GROUP#	ID#	GROUP#
Policy Holder Name (If different from Patient): Self ☐		Policy Holder Name(if different from Patient): Self ☐	
Policy Holder Address(If different from Patient):		Policy Holder Address(If different from Patient):	
Date of Birth: Sex: M ☐ F ☐		Date of Birth: Sex: M ☐ F ☐	
Relationship to Patient:	Phone #	Relationship to Patient:	Phone #

EMERGENCY CONTACT

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

Is this a Worker's Compensation Claim? Yes ☐ No ☐. If yes, Claim Number: _____ Date of Injury: _____

Is this a Motor Vehicle Claim? Yes ☐ No ☐. If yes, Claim Number: _____ Date of Injury: _____

PAYMENT POLICY

It is our payment policy to collect the appropriate payment due from the patient at the time of service is rendered. This may only be your co-payment, co-insurance and/or deductible according to your health insurance company benefit plan, but we do ask for payment at the time of your visit.

1. If you are a Medicare recipient, we will file your Medicare claim as required for our participation in the Medicare program. Medicare normally forwards claims to your secondary (supplementary) insurance, if any, for processing of co-insurance or deductibles. This does not guarantee your secondary insurance will pay these balances.
2. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to verify your insurance benefits; however, you are responsible for knowing the benefits/coverage of your insurance.

Initial: _____

Please complete the back of this page.

PATIENT AUTHORIZATION AND RELEASE

I HAVE READ AND UNDERSTAND the above statements. I agree to assign Precision Imaging all insurance benefits for services rendered. I authorize the use and disclosure of all medical records necessary for the purpose to secure payment of services. I understand that I am financially responsible for all charges.

Patients' Signature (or parent, if minor): _____ Date: _____

Receipt of Privacy Practices: I certify that I have received, at this visit or a previous visit, a copy of Precision Imaging's Notice of Privacy Practices:

Signature: _____ Date: _____

I give my permission for Precision Imaging to discuss my Protected Health Information with the persons listed below (exclude all physicians):

Name_____Relationship_____

Name_____Relationship_____

ELECTRONIC MEDICAL RECORD DEMOGRAPHICS

We are required to obtain the following information in order to be compliant with Federal Government Meaningful Use regulations.

RACE:

☐ Asian
☐ American Indian or Alaska Native
☐ Black/African
☐ Native Hawaiian or other Pacific Islander
☐ Caucasian/White
☐ Unreported

ETHNICITY:

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unreported

Preferred Language:

☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Other: _____

Smoking Status:

☐ Currently Smoke Every Day ☐ Smoke Occasionally ☐ Former Smoker ☐ Never Smoked ☐ Decline to Answer

List Allergies	Severity (mild/mod/severe)	Current Medications (If you have a list, we can copy)	Dosage

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CT Patient Questionnaire

Name_____ DOB_____

Referring Physician_____

Primary Care Physician_____

Reason for Today's Exam_____

Have you had a previous CT before? Yes☐ No☐
If yes, where? And when?_____

Have you had a previous CONTRAST reaction? Yes☐ No☐
If yes, what kind?_____

Do you have or ever had any type of cancer? Yes☐ No☐
If yes, what kind?_____

Have you had any type of surgery? Yes☐ No☐
If yes, what kind?_____

Do you have Diabetes? Yes☐ No☐
If yes, what medication are you taking?_____

Any chance of pregnancy? Yes☐ No☐
If no, when was your last menstrual period?_____

Have you had chemo or radiation? Yes☐ No☐
Any kidney disease, failure, or transplant? Yes☐ No☐
Sickle Cell Disease Yes☐ No☐
Multiple Myeloma Yes☐ No☐
High Blood Pressure Yes☐ No☐
Thyroid Disorder Yes☐ No☐
Asthma Yes☐ No☐

Patient Signature_____ Date_____

Techs only
IV Contrast Type_____, _____ml@ _____ sec. del_____ Inj. Site_____ Gauge_____ Tech_____ BUN_____ CREAT_____ GFR_____ Oral Contrast/Amt._____