ONSITE RADIOLOGIST

REGISTRATION FORM

Date:	Referring Physician/ Clinic:

PATIENT INFORMATION

Patient's Name:	SSN:	DOB:	Sex:
Street address:	City:	State:	
ZIP Code:	Cell Phone:	Home Phone:	
Occupation:	Employer:	Employer phone no.: ( )	
Referred By:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	DOB:	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No ❑ Self-Pay			

Primary insurance Company:	Subscriber's Name:

Subscriber's S.S. no.:	DOB:	Group no.:	Policy no.:	Co-pay:$
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				

Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell phone no.: ( )	Home phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Onsite Radiologist. I understand that I am financially responsible for any balance. I also authorize Onsite RADIOLOGIST or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

CT Screening Sheet

Patient's Name:____ Date:______________________

DOB:__________ Weight:_____________________ Sex: M or F Height:______________________

PCP:____

Area to be Scanned:____

Reason for Scan (what symptoms do you have):____

Have you had a radiology procedure with any injection of dye or contrast? ☐ Yes ☐ No

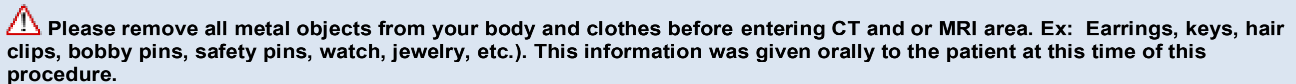
If yes, did you have any allergic reaction? ☐ Yes ☐ No

If Yes, Describe:____

Are you or have you ever been a smoker? ☐ Yes ☐ No

If yes, then how long?____

Have you quit? ☐ Yes ☐ No If Yes, when did you quit? _______________________________



Please remove all metal objects from your body and clothes before entering CT and or MRI area. Ex: Earrings, keys, hair clips, bobby pins, safety pins, watch, jewelry, etc.). This information was given orally to the patient at this time of this procedure.

Do you have any of the following?

☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Any back Surgery
☐ Yes	☐ No	Are you allergic to Iodine	☐ Yes	☐ No	Any neck Surgery
☐ Yes	☐ No	Previous adverse reaction to contrast	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Any history of Cancer	☐ Yes	☐ No	Chance of pregnancy
☐ Yes	☐ No	Heart or vascular surgery	☐ Yes	☐ No	Renal Disease
☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Latex Allergy
☐ Yes	☐ No	Arm Pain	☐ Yes	☐ No	Leg Pain
☐ Yes	☐ No	Sickle cell Disease	☐ Yes	☐ No	Are you taking Glucophage
☐ Yes	☐ No	History of Asthma or any allergy			

If Yes to Diabetes, what medication do you take for Diabetes? ________________________________

Have you had any surgery on the area to be examined? ☐ Yes ☐ No

If Yes, When?________________________________ Where:______________________________

Describe what was done:____

____

Please indicate if you had any prior x-ray studies (x-rays, CT's, MRI's etc.) ☐ Yes ☐ No

If Yes, what type and Facility? ____

I hereby certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Onsite Radiologist employees of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in by body, and after consultation with a physician, elect to proceed with the MRI procedure I agree to release Onsite Radiologist from all liability for any injury.

_______________________________________ ______________________

Patient/Guardian Signature Date

ONSITE RADIOLOGIST

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of Onsite Radiologist Notice of Privacy Practices. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of ONSITE RADIOLOGIST. I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any Questions with regard to this Notice of Privacy Practices, I may contact Privacy Officer

Onsite Radiologist 3547 Peachtree Industrial Blvd. Duluth GA 30097
Phone: 770-299-1332 / 770-299-1344
Fax: 770-741-0097

______________________________ ______________________________
Signature Date

____
PRINT NAME

If completed by a patient's personal representative, please print and sign your name in the space below

______________________________ ______________________________
Personal Representative Signature Date

____
Relationship

For ONSITE RADIOLOGIST Use Only

Complete this section if this form is not signed and dated by the patient or patient's personal representative

I have made a good faith effort to obtain a written acknowledgement of receipt of Onsite Radiologist Notice of Privacy Practices but was unable to for the following reason

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other: ______________________________

____
Employee Name Date

ONSITE RADIOLOGIST

ONSITE RADIOLOGIST MRI – CT – Ultrasound www.onsiteradiologist.com info@onsiteradiologist.com	3547 Peachtree Industrial Blvd. Suite#4 Duluth GA 30096 770-299-1332 770-741-0097

X-RAY/ CT/ MRI PREGNANCY CONSENT

Patient Name:______________________________ Date: ______________

Date of Birth:________________ Referring Physician: ______________________

MUST BE COMPLETED FOR/ OR BY ALL WOMEN BETWEEN THE AGES OF 11-50

The radiation used in X-Ray/ CT may be harmful to an unborn child. To help prevent the accidental irradiation of an unrecognized pregnancy, and in accordance with national standards, we required the following information from female patients of childbearing age. If any of the information below indicated even the remote possibility of pregnancy, your referring physician will be asked to order a urine or serum pregnancy test prior to any imaging.

Please answer the following questions:

1. Are you, or is it possible that you might be pregnant? Y or N or Unsure
2. Are you currently breastfeeding? Y or N
3. Method of Birth Control: ______________________________

   If you are not currently on birth control, have you had sexual activity since your last menstrual period that may put you at risk for pregnancy Y or N

4. First day of last menstrual period (LMP)?

I, (patient or responsible party) have been fully informed of the risks involved in radiating a first trimester pregnancy and assume the responsibility for any consequences from the procedures I am about to have. I also will not hold Onsite Radiologist, the employees of the facility, and/ or American Radiologist Association responsible for any potential harm to my unborn child or myself.

______________________ ______________________ ______________

Print Name of Patient or responsible party | Signature of Patient or responsible party | Date