LANDMARK IMAGING
MEDICAL GROUP INC

PATIENT REGISTRATION

Name Social Security # - -
Last *First* *Middle*
Address Birth Date: Cell phone ( ) Age

City St Zip Sex: M ☐ F ☐ Date of Injury

Phone ( ) - Referred by:

Accident? Yes ☐ No ☐ / Auto ☐ Work ☐ Other ☐ Employment Status: Employed ☐ Student ☐ (F/T-P/T)

Employer Occupation Work Phone ( ) -

Nearest Relative/Friend Not Living with You Phone ( ) -

Spouse Name Spouse Employed by: Phone ( ) -

Insurance Information

Medical Ins. Co. #1

Social Sec. #
Of Insured - - Policy# or Group# Relationship to patient

Insured's Name Authorization:

DOB of Insured Employer Insurance Name

Address City St Zip Phone ( ) -

Medical Ins. Co. #2

Social Sec. #
Of Insured - - Policy# or Group# Relationship to patient

Insured's Name Authorization:

DOB of Insured Employer Insurance Name

Address City St. Zip Phone ( ) -

Attorney? Yes ☐ No ☐ Attorney Name: Phone ( ) -

Auto/Work Comp Ins. (Name/Address)

Adjuster Name Phone ( ) -

I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING MEDICAL GROUP, INC** I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature _____ Date _____

11620 Wilshire Blvd., Suite 100 Los Angeles, CA 90025 Phone 310.914.7336 Fax 310.914.7326
www.landmarkimaging.com

LANDMARK IMAGING
MEDICAL GROUP INC

CT PATIENT CLINICAL HISTORY

PATIENT NAME: _____ DATE: _____
DATE OF BIRTH: _____
PROCEDURE_____
REFERRING PHYSICIAN: _____
ADDITIONAL COPY OF REPORT TO WHOM? _____

1. Chief complaints/Reason for exam? _____
2. How long have you had this problem?_____
3. Have you had any surgeries? ☐ YES ☐ NO
   If yes, describe surgeries and give dates._____
   _____
   _____
4. Have you had any radiology exams or other tests for this problem, or other problems?
   ☐ YES ☐ NO
   If yes, please list dates, tests, and results, if you know._____
   _____
   _____
5. Do you have a history of:

Heart disease?	☐ YES ☐ NO	Hypertension?	☐ YES ☐ NO
Diabetes mellitus?	☐ YES ☐ NO	Kidney disease?	☐ YES ☐ NO
Multiple myeloma?	☐ YES ☐ NO	Asthma?	☐ YES ☐ NO
Chronic lung disease?	☐ YES ☐ NO	Pulmonary hypertension?	☐ YES ☐ NO
Use of Glucophage (metformin)?		☐ YES ☐ NO	
Sickle cell disease or Sickle cell anemia?		☐ YES ☐ NO	

   Do you currently smoke? ☐ YES ☐ NO Have you smoked in the past? ☐ YES ☐ NO
   If yes, how many years? _____ Months? _____.
   Other major medical problems, please list: _____
   _____
6. Any history of cancer? ☐ YES ☐ NO If yes, what cancer?_____
7. Are you pregnant, or might you be? ☐ YES ☐ NO
8. Date of last menstrual period?_____
9. Have you had an injection of iodinated contrast (x-ray dye) before (e.g. CT Scan, IVP)?
   ☐ YES ☐ NO
10. Do you have a known allergy to iodinated contrast (x-ray dye), or to any medication?
    ☐ YES ☐ NO
    If yes, please describe and tell the technologist before you have your study performed.
    _____
11. Is this study being ordered because of an injury? Job related injury? ☐ YES ☐ NO
12. Have you had a Barium study in the past two weeks? ☐ YES ☐ NO

11620 Wilshire Blvd., Suite 100 Los Angeles, CA 90025 Phone 310.914.7336 Fax 310.914.7326
www.landmarkimaging.com