

PATIENT REGISTRATION

Name			Social Security #					
Last Address	First	<i>Middle</i> Birth Date:	С	ell phon	e()	A	Age	
City	St	Zip	Sex: M □	F []	Date of Injury			
Phone ()	-	Referred by:						
Accident? Yes No	/ Auto 🛮 Work 🖺	Other []	Employmer	nt Status	: Employed [] S	Student []	(F/T-P/T)	
Employer		Occupation		Wo	ork Phone ()	-	
Nearest Relative/Friend N	ot Living with You				Phone ()	-	
Spouse Name		Spouse Employed by:			Phone ()	-	
0		Insurance Informat Medical Ins. Co. #1	ion					
Social Sec. # Of Insured -	-	Policy# or Group#			Relationship to	patient		
Insured's Name			Authoriza	ition:				
DOB of Insured	Employer		Insurance	Name				
Address		City	St	Zip	Phone ()	-	
Social Sec. #		Medical Ins. Co. #2						
Of Insured -	-	Policy# or Group#			Relationship	to patient	İ	
Insured's Name			Authorizati	ion:				
DOB of Insured	Employer		Insurance Name					
Address		City	St.	Zip	Phone ()	-	
Attorney? Yes [] No []	Attorney Name:				Phone ()	-	
Auto/Work Comp Ins. (Na	ame/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.								
ignature Date								



CT PATIENT CLINICAL HISTORY

Heart disease?	PA	TIENT NAME:		DATE:						
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? 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										
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Heart disease?		,, p,	, , , , , , , , , , , , , , , , , , , ,	,						
Heart disease?										
Diabetes mellitus?	5.	Do you have a history of	:							
Multiple myeloma?		Heart disease?	☐YES ☐NO	Hypertension?	☐YES ☐ NO					
Multiple myeloma?		Diabetes mellitus?	∏ YES ∏ NO	Kidney disease?	∏YES ∏NO					
Chronic lung disease?		Multiple myeloma?	 ∏ YES ∏ NO							
Use of Glucophage (metformin)?		· · ·		Pulmonary hypertension?						
Sickle cell disease or Sickle cell anemia?										
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		. • ,								
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	11	Is this study being order	ed because of an in	iurv? .loh related iniurv? □ V	FS I NO					
12. Have you had a Barium study in the past two weeks?		•		• • • • •						