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

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ULTRASOUND PATIENT CLINICAL HISTORY

PLEASE PRINT CLEARLY

NAME: ____AGE: ___________SEX: _____
Last First Middle

DATE OF BIRTH: ___________________________HEIGHT: __________________WEIGHT: ________

MEDICAL HISTORY

Physician's Name: ___________________ Address: ____________________ Phone #: __________

Have you been a patient in a hospital in the past 5 years? YES NO Reason: ____________________

Have you had any serious illnesses or operations? YES NO

List Operations:____

____

FOR WOMEN ONLY: Are you or do you think you could be pregnant? YES NO

Date last menstrual period began: _________________________

If you think you may be pregnant, please notify the technologist before your exam!

#	Description	Yes	No	#	Description	Yes	No	#	Description	Yes	No
1	Heart Disease			10	Arthritis			18	Allergies to:		
2	High Cholesterol or High Lipids			11	Tumor History				Penicillin		
3	Family History of Heart Disease			12	Radiation Treatment				Other Antibiotics		
4	High Blood Pressure			13	Liver or Kidney Disease				Codeine, Aspirin		
5	Rheumatic Fever			14	Hepatitis (A, B, C), Jaundice				Local Anesthetic		
6	Thyroid disease			15	AIDS / HIV +				Other		
7	Diabetes			16	Asthma, Emphysema, Bronchitis			19	Do you smoke?		
8	Stroke			17	Tuberculosis			20	Have you ever smoked?		
9	Heart Attack							21	How many years?		

Please list any disease, condition, or problem not listed above:
____
____
____

List any medication, drugs, pills (prescription or non-prescription) you are currently taking:
____
____

REMARKS:
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