



Date _____

Referring Physician _____

PATIENT				SUBSCRIBER'S NAME			
FIRST NAME (Please Print)		Middle Initial		FIRST NAME (Please Print)		Middle Initial	
LAST NAME				LAST NAME			
STREET ADDRESS				STREET ADDRESS			
CITY, STATE		ZIP CODE		CITY, STATE		ZIP CODE	
HOME PHONE		WORK PHONE		HOME PHONE		WORK PHONE	
SOCIAL SECURITY NUMBER		CELL PHONE		SOCIAL SECURITY NUMBER		CELL PHONE	
EMPLOYER		OCCUPATION		EMPLOYER		OCCUPATION	
SEX	MARITAL STATUS			SEX	MARITAL STATUS		
BIRTHDATE		AGE		BIRTHDATE		AGE	
RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____							
NAME, ADDRESS AND PHONE OF PERSON NOT LIVING WITH YOU, TO CONTACT IN CASE OF EMERGENCY							
GIVE A BRIEF HISTORY OF YOUR ILLNESS:							

INSURANCE INFORMATION	
PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
ADDRESS	ADDRESS
INSURANCE I.D.#	INSURANCE I.D.#
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
IS INJURY A RESULT OF CAR ACCIDENT? _____ (If yes, give name & address of auto carrier in above spaces)	IS X-RAY FOR WORKMANS COMPENSATION? _____ IF YES, GIVE DATE OF INJURY _____

ACKNOWLEDGEMENT OF RECEIPT OF OF PRIVACY NOTICE

I acknowledge that I have been offered/received a copy of the Provider's Notice of Privacy Practices with the effective date of April 28, 2003.

_____ has permission to obtain my medical records. Signed _____ Date _____

AUTHORIZATION TO OBTAIN MEDICAL RECORDS:

I hereby authorize Wichita Radiological Group to obtain any and all of my medical records.

Signed _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby assign and authorize for direct payment for radiological and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance.

Signed _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Wichita Radiological Group to release any information acquired in the course of my examination or treatment to my referring doctor and/or insurance company.

Signed _____ Date _____

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

IMAGING SERVICES PATIENT HISTORY

Height _____ feet _____ inches

Current Weight _____ lbs

Describe your symptoms below:

Date symptoms began: _____

Was this a result of an injury? (circle one)

Yes No

Have you ever been diagnosed with cancer? (circle one)

Yes No

If yes, what type? _____

Treatment: Chemotherapy (circle one)

Yes No

Radiation (circle one)

Yes No

Are you diabetic? (circle one) Yes No Medication: _____

Have you had a previous study pertaining to this diagnosis: (circle one)

CT: Yes No If yes, where? _____

MRI: Yes No If yes, where? _____

Nuc Med: Yes No If yes, where? _____

List surgeries and dates performed: _____

Do you smoke or do you have a hx of smoking? (circle one)

Yes No

Do you have a history of multiple myeloma? (circle one)

Yes No

Do you have any implanted devices in your body? (circle one)

Yes No

ANY POSITIVE RESPONSE BELOW REQUIRES RADIOLOGIST REVIEW:

Are you pregnant? Yes No Comments: _____

Have only one kidney? Yes No Comments: _____

Kidney disease? Yes No Comments: _____

Breast feeding? Yes No Comments: _____

Medication for diabetes? Yes No Comments: _____

Previous reaction to contrast? Yes No Comments: _____

List all medications and dosages:

Patient Signature: _____ Date: _____

*Important: If patient is unable to sign, please note and the technologist signature required.

PLEASE DO NOT WRITE BELOW THIS LINE; IMAGING USE ONLY:

Contrast allergies noted.

Proceed with procedure.

_____ Date: _____ Time: _____

Physician Signature (required if any "yes" checked above)

Contrast Premedication _____ Time: _____ BUN: _____ Creatinine: _____

IV Contrast: _____ Dose: _____ cc's Site: _____ Time: _____ By: _____

Saline/Lock Location: _____ @ _____ With: _____ gauge _____ attempt

PA/RN/Tech: _____ Saline lock removed @ _____