PATIENT REGISTRATION INFORMATION

Today's Date: ____/____/____ Referring Physician: _____

Patient Information

Last name: _____ First name: _____ Middle Initial: ____

Social Security # _____ Sex: Male ( ) Female ( ) Date of Birth: ____/____/____

Address: _____ Apt # _____

City, State, ZIP Code: _____

Home Phone # _____ Alt. /Cell # _____

Emergency Contact: Name _____ Relationship_____

Home Phone # _____ Alt. /Cell # _____

Patient's Employment: Full Time____ Part Time ____ Retired ____ Not Employed ____ Student____

Employer: _____ Work phone # _____

Address: _____

Primary Insured: _____ Self (Skip to Primary Insurance Section)

Name & Relationship to Patient: _____ Date of Birth: ____/____/____

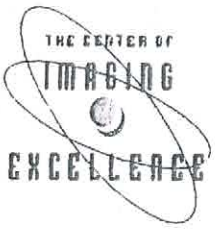
Primary Insurance: _____

Policy # _____ Group # _____

Secondary Insurance: _____

Policy # _____ Group # _____

2003–A Whitesburg Drive, Huntsville, AL 35801 –Phone (256) 536-3550 Fax (256) 536-3554



PATIENT AGREEMENT AND ACKNOWLEDGEMENT FORM

I understand payment of all insurance benefits for this period of service must be made directly to The Center of Imaging Excellence. If a check must be made out to me, I understand that the check must be sent to The Center of Imaging Excellence at the address listed at the bottom of this page.

Initial _____

I understand The Center of Imaging Excellence must collect for all the charges not covered by insurance payment. Payment for all collection costs is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

Initial _____

I hereby consent to The Center of Imaging Excellence to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetics as necessary and any other general medical/emergency treatment and hospital care considered advisable or necessary by the physician.

Initial _____

Acknowledgement to use and disclose health information for treatment, payment, or healthcare operations (HIPAA pamphlet available on the front desk counter). I understand and have been offered a copy of the Privacy Practices of The Center of Imaging Excellence.

Initial _____

I have read and do understand the above statements and I have willingly signed.

_____ _____

Signature of the Patient / Guardian Date

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Ultrasound Screening Sheet

Explain your medical problem. _____

How long have you had this problem? _____

Have you had any test done related to this problem? _____
If so.. Where and When? _____

Is this related to an injury? _____
If so.. list date of injury. _____

Are you allergic to anything? _____

Have you ever had renal (kidney) problems? _____

Have you ever been diagnosed with cancer?_____

Are you diabetic and if so, what medication do you take? _____

Please list any surgeries with APPROXIMATE dates. _____

(For women only)

Is there any chance of you being pregnant? Yes No

Date of last monthly period? _____

Have you had a hysterectomy? Yes No Were your ovaries removed? Yes No

I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient Signature _____. Date _____