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: ____/____/____

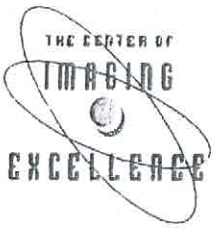
Primary Insurance: _____

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

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

THE CENTER OF IMAGING EXCELLENCE

Bone Density Screening Questionnaire

Height: _____

Weight: _____

Have you had a Hysterectomy? _____

Age of Hysterectomy or Menopause? _____

Are you using hormones in the form of pills, patches, pellets, or injections? _____

Have you taken hormone blocking medications for treatment of cancer? _____

Do you have a family history of osteoporosis in a first degree relative (mother, father, sister, brother)?
If yes, who? _____

Have you had any broken bones as an adult? If yes, which? _____

Do you smoke? _____

Do you take calcium or vitamins? _____

Do you take any medications? If yes, please list:

_____

Have you ever had back or hip surgery? _____

If yes, do you have any metal in hip or spine? _____

Have you ever had Gastric bypass or Gastric sleeve surgery? _____

Have you had a bone density test before? If yes, where? _____

Have you had intravenous (IV) or oral contrast (barium) for another radiology study in the past week?

If yes, what exam did you have? _____

Signature of Patient or Patient Representative: _____