Registration Form

Patient Name First MI Last				Date of Birth	Age
Home Address Apt #		City		State	Zipcode
Social Security #		Sex ◯ M ◯ F		Home Phone	
Employer Name				Work Phone	
Referred by Dr.		Date of Injury/Illness		Cell Phone	
If Work Comp Related, Employer Where Injury Occurred		Auto Accident Related? ◯ Y ◯ N		Restrictions when leaving message/voicemail: YES:	

Assignment of Insurance Benefits: I hereby authorize payment directly to the Center listed above. In the event payments are made directly to me, I agree to remit such payment to the Center. Should my Insurance Company or Attorney refuse to honor the bill, I agree to be responsible for the balance. I further agree to be responsible for said debt and any collection fees or Attorney fees involved in the collection of this debt.

Patient Signature: **Date:**

Release of Information: This authorization or photo copy hereof will authorize the release of the requested medical records/reports and or any other records when necessary to Insurance Carriers and Review Agencies responsible for pre-certification and payment for services rendered. My report may also be released to requesting physicians as to not impede or delay treatment. I further authorize release of such medical records associated for the performance of services requested by me or on my behalf. **Patient Signature:**

Date:

Duplicate Film Charge: One set of film will be provided with your procedure. For any request for extra film, there will be a charge of $25 per sheet or $30 for a CD.

Initial _____

Acknowledgment Receipt of Notice of Privacy Practices

I, _____ understand that under HIPAA regulations, I have the

right to request and receive a paper copy of the Notice of Privacy Practices.

☐ Even if I have agreed to receive this notice electronically, I am still entitled to a paper copy.

☐ I understand I am entitled to receive a paper copy and have chosen not to take it.

If signature is not obtained, please explain why: _____

_____ _____

Signature of Patient Date

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UNIVERSITY MEDICAL IMAGING
X-Ray Patient Intake Questionnaire

Patient Name: _____ Weight: _____ DOB: _____

1. What is the reason or health problem that your physician ordered this exam for you?

_____

_____

2. What are your symptoms related to your exam today?

_____

_____

3. If spine injury, check if any apply to you:

	Left Arm	Right Arm	Left Leg	Right Leg
Pain				
Numbness				

4. What was your date of injury and/or onset of symptoms? _____

5. Have you had a previous X-ray or other type of diagnostic exam of the area we are imaging today? Yes ◯ No ◯

6. If yes, where and when? _____

X-RAY SAFETY QUESTIONNAIRE

X-Ray Procedures are non-invasive and generally safe, however if any of the following exist, special preparations may be required. Please check Yes or No to indicate if you have had any of the following:

Y	N	
◯	◯	Are you Pregnant or is there a possiblity you may be Pregnant?
◯	◯	Have you had surgery in the area we will be imaging today?
◯	◯	Allergies to Medication/ Latex

Patient Signature: _____ Date: _____

TECHNICIAN USE ONLY: _____ TECH INITIALS: _____

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