

Chart # _____ APPT BY: _____
 Patient Name _____ DOB _____
 Address _____ APT# _____ City _____ Zip _____
 Phone # _____ SS# _____ Email: (appointment alerts) _____

Work status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
How were you referred to our office <input type="checkbox"/> Referring Dr <input type="checkbox"/> Internet <input type="checkbox"/> Zoc Doc <input type="checkbox"/> Returning Patient <input type="checkbox"/> ETC. _____ When is your follow up appointment with your doctor regarding this study? _____

Employer _____ Employer's Address _____
 Emergency contact person _____ phone # _____

INSURANCE INFORMATION

Is this related to an accident	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes, <input type="checkbox"/> Auto, <input type="checkbox"/> W.Comp. <input type="checkbox"/> Other
Date of accident : _____	State Auto Injury occurred in: _____
Attorney Name: _____	Phone# _____
Are you treating with a Chiropractor <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____ Phone: _____

PRIMARY

Authorization # _____

Name Insurance: _____	Id # _____	Group # _____
Phone # _____	Insurance Address _____	Adj Info _____
Subscriber name _____	D.O.B/ S.S.# _____	Relationship _____

SECONDARY

Authorization # _____

Name Insurance: _____	Id # _____	Group # _____
Phone # _____	Insurance Address _____	Adj Info _____
Subscriber name _____	D.O.B/ S.S.# _____	Relationship _____

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare patients) and all other third party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand if my account is sent to collection for payment, I will incur additional charges (a minimum of 25%) on the amount sent; this applies to co payments as well. This is for today's service and any future services at Middletown Medical Imaging. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

This facility will provide a locker in which you must store your personal items and valuables. Please lock these items in the area provided, and bring the key with you into the scan room for security. Middletown Medical Imaging will not accept liability for any personal belongings.

I hereby authorize Middletown Medical Imaging to deliver my imaging studies to the referring physician or specialist at his/her request. I understand that these studies are a permanent part of my medical record. I hereby release Middletown Medical Imaging from any and all legal responsibility or liability that may arise from release of these films. I have been offered a copy of the HIPPA compliance and understand and agree to its terms.

Signature

Today's date

All patients/legal guardians must REVIEW, SIGN and DATE all paperwork.

CT QUESTIONNAIRE

APPT BY: _____

APPOINTMENT DATE _____ TIME _____

Do You Have A Follow-up Appt. with your Doctor? _____ When? _____

Patient's Name _____ DOB _____ (Circle) Male/Female

Type of Scan _____ R/O _____

Referring Physician _____ Phone # _____

Weight _____ Age _____ (Any patient with diabetes, kidney failures or over 60 must have blood work)

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Any history of smoking	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Are you allergic to iodine or contrast dye	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	If so, what happens _____
Are you allergic to shellfish	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	If so, what happens _____
Do you have any allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Do you have any history of asthma or difficulty breathing	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Are you diabetic/Blood work needed	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	If yes, what medication do you take _____
Are you on Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	IF SO PATIENT MUST SCHEDULE DIALYSIS AFTER SCAN
Do you have any kidney/renal disease	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Do you have any history of cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	If so, what happens _____
Is there a possibility you might be pregnant	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	LAST LMP _____
Are you able to walk without assistance	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Patient over 60 MUST they have blood work	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	FRONT DESK MUST OBTAIN BLOODWORK (LABS: BUN, GFR, CREATINE)
Have you had any previous exams of the same body part	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	

NOTES/SPECIAL INSTRUCTIONS:

Attachments: Prior Exam Blood work Script

Patient/Guardian Signature: _____ Date: _____

PATIENT: Please review the information provided at the time of scheduling. Your Signature will verify its accuracy

Front Desk Only: Date: _____ CONFIRMED LEFT MESSAGE NO ANSWER

For Contrast studies: instructed patient to drink water



MIDDLETOWN MEDICAL IMAGING

3T MRI • Open MRI • Low Dose CT • Ultrasound • Digital X-Ray

CLINICAL QUESTIONNAIRE

Name: _____ Date: _____

Allergies: _____

- Why has your doctor sent you for this test? Did she/he give you a specific diagnosis?

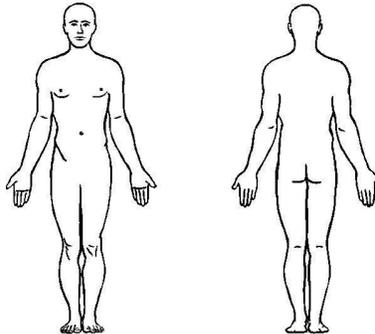
- Please describe what specific complaints/symptoms have been most bothersome to you?

- How long have you had these complaints/symptoms? _____
- Did these complaints/symptoms come on suddenly or gradually? _____
- These complaints/symptoms have:
_____ improved _____ remained the same _____ worsened
- Have you had any previous surgery related to today's exam? ___ Yes ___ No
(If Yes, type and date: _____)
- Have you had any prior tests related to today's exam, if so what were the results of the test? _____
- Do you have any history of any cancer? ___ Yes ___ No
- Do you have a history of smoking? ___ Yes ___ No

FEMALE PATIENTS:

- Are you pregnant? ___ Yes ___ No ___ N/A
- Date of Last Menstrual Period _____

**Circle region
of pain:**



Patient Signature: _____

Date: _____



M I D D L E T O W N
M E D I C A L I M A G I N G

1275 Route 35 N
Middletown, NJ 07748
(732) 275-0999

PATIENT NAME: _____

DOB: ____ / ____ / ____ **PATIENT SOCIAL SECURITY #:** ____ - ____ - ____

REVIEW OF OUTSIDE FILMS POLICY:

Please make available to the front office any prior imaging films, CD's, and reports at the time of your appointment. This pertains solely to any exams performed at any outside facilities other than Middletown Medical Imaging. Please be advised that if you fail to bring your prior exam at the time of your appointment there will be a \$100.00 "Review of Outside Film" charge for any comparison performed after your original appointment date.

DISC AND FILM RELEASE:

I hereby release Middletown Medical Imaging located at 1275 Route 35 North in Middletown, NJ from any and all legal responsibility or liability that may arise from release of records. For any additional disc or films a fee will be charged. The fee for a disc will be \$25.00 and films will cost \$75.00.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby request you to release my medical records to/from Middletown Medical Imaging. Please fax all records to 732-275-0979.

Name of Referring Doctor or Organization: _____
Ph#: _____ FX#: _____

X: _____
SIGNATURE OF PATIENT OR REPRESENTATIVE:

Date: ____ / ____ / ____