Chesapeake Regional Imaging	Exam Date and Time:	MRN/Jacket:	Patient Registration

Name: ______________________________

Address: ______________________________ City, State, Zip: ______________________________

Home Phone: ______________________________ Mobile Phone: ______________________________

Email: ______________________________ Date of Birth: ______________________________

Race: __________ Gender: __________ Marital Status: ______________________________

SSN: ______________________________

Referring Physician: ______________________________

Emergency Contact Information

Name: ______________________________ Contact Phone: ______________________________

Insurance

Primary Insurance Plan Name: ______________________________

Policy #: ______________________________ Group #: ______________________________

Secondary Insurance Plan Name: ______________________________

Policy #: ______________________________ Group #: ______________________________

Relationship to Insured

Insured Name: ______________________________ Relationship to Patient: ______________________________

Insured DOB: ______________________________

Auto Accident or Worker's Compensation Information

Is this injury due to accident? Yes ☐ No ☐ If yes, what type of Accident? ______________________________

Accident Date: ______________________________ Accident State: ______________________________

Patient Name: **MRN/Jacket #:**

By signing below, I agree to the following for outpatient radiology care provided by Chesapeake Regional Imaging

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, Chesapeake Regional Imaging may use and disclose my protected health information for treatment, payment and health care operations as explained in the Chesapeake Regional Imaging. Notice of Privacy Practices. I also authorize release of my protected health information to Chesapeake Regional Imaging, the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?

Yes ☐ No ☐

MEDICAL RECORDS CAN BE RELEASED TO:

Name: ______________________________ Date of Birth: ___________________ Relationship to Patient: ____________________________

Financial Responsibility

With this consent, I authorize Chesapeake Regional Imaging and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to Chesapeake Regional Imaging on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, Chesapeake Regional Imaging may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that Chesapeake Regional Imaging has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Chesapeake Regional Imaging may decline to provide treatment to me.

Signature: ____ **Date:** ___________________

Printed Name: ____

CHESAPEAKE REGIONAL IMAGING CENTERS

CT HISTORY FORM

Patient Name: ____

DOB: ______________ Age: ______________Height: ______________ Current weight: ______________

Have you had a previous imaging study related to this problem? □ **Yes** □ **No**

If yes. What exam? □ **CT** □ **MRI** □ **Ultrasound** □ **X-ray** □ **Other** What Facility? ______________

PERSONAL HISTORY

Have you ever had a allergic reaction to injected CT or x-ray contrast (x-ray dye) □ **Yes** □ **No**

If yes, explain: ____

□ **Yes** □ **No** Heart Disease

□ **Yes** □ **No** High Blood Pressure

□ **Yes** □ **No** Asthma/Other Lung Disease

□ **Yes** □ **No** Kidney Disease/ Kidney Failure

□ **Yes** □ **No** Diabetes

□ **Yes** □ **No** Dialysis

□ **Yes** □ **No** Do you take Metformin hydrochloride (Glucophage, Glucovance, Avandement, Metaglip, or Fortamet?)

□ **Yes** □ **No** Allergies If yes, please specify: ______________________________

□ **Yes** □ **No** Surgeries If yes, please specify: ______________________________

□ **Yes** □ **No** Cancer If yes, please specify: ______________________________

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? □ **Yes** □ **No** Date of last period: ______________________________

ACKNOWLEDGEMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

Patient/ Guardian Signature: ______________________________ Date: ______________________________

Technologists Signature: ______________________________ Date: ______________________________