

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



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 Please indicate if you have any of the following:**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Swan-Ganz or thermodilution catheter            | <input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or ventricular)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker                               | <input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expander (e.g. breast)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Cardioverter defibrillator (ICD)      | <input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (limb, eye, penile, etc)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm Clip(s)                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Metallic Stent, filter, or coil  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid spring or wire                           | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD, diaphragm, or pessary   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve prosthesis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh implant Surgical staples, clips, or metallic sutures                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neuro or Spinal Cord Stimulator                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Medication Patch (Nicotine, Nitroglycerine)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal electrodes or wires                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoo of permanent make-up  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth / Bone Stimulator                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures or partial plates   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or other ear implant        | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing jewelry  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug/insulin infusion device          | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Aid  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement (hip, knee, etc.)             | <input type="checkbox"/> Yes <input type="checkbox"/> No Any metallic fragment or shavings, BB, shrapnel or foreign body (including eye injuries) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate, etc.) |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any other implant: _____                        |   |

**PERSONAL HISTORY**

Have you ever had a previous allergic reaction to injected MRI contrast  Yes  No

If yes, explain: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure Disorder                        | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease/ Kidney Failure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart or Blood Disease         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies If yes, please specify: _____ |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeries If yes, please specify: _____ |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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 attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious effects by receiving gadolinium based contrast agents.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologists Signature: \_\_\_\_\_ Date: \_\_\_\_\_