NORTH DOVER RADIOLOGY

Chart #_____ APPT BY: _____

Patient Name_____ DOB_____

Address_____ APT# _____ City_____ Zip _____

Phone #_____ SS#_____ Email: (appointment alerts)_____

Work status	☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐Student
Marital status	☐ Single ☐ Married ☐ Widowed ☐ Divorced
How were you referred to our office	☐ Referring Dr ☐ Internet ☐ Zoc Doc ☐ Returning Patient ☐ 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	☐ Yes ☐No ☐ NA If yes, ☐ Auto, ☐ W.Comp. ☐ Other
Date of accident : _____	State Auto Injury occurred in: _____

Attorney Name: _____	Phone#_____
Are you treating with a Chiropractor ☐ Yes ☐ 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 North Dover Radiology. 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. North Dover Radiology will not accept liability for any personal belongings.

I hereby authorize North Dover Radiology 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 North Dover Radiology 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.

NORTH DOVER RADIOLOGY

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)**

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

NORTH DOVER
RADIOLOGY

Open MRI • CT • Ultrasound • Mammography • DEXA • Digital X-Ray

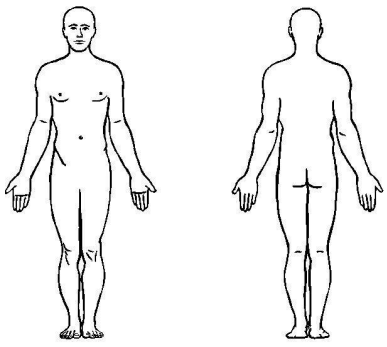
CLINICAL QUESTIONNAIRE

Name:_____ Date:_____

Allergies: _____

1. Why has your doctor sent you for this test? Did she/he give you a specific diagnosis?
   _____
   _____
   _____
2. Please describe what specific complaints/symptoms have been most bothersome to you?
   _____
   _____
   _____
3. How long have you had these complaints/symptoms? _____
4. Did these complaints/symptoms come on suddenly or gradually? _____
5. These complaints/symptoms have:
   _____improved _____remained the same _____worsened
6. Have you had any previous surgery related to today's exam? ____Yes ____No
   (If Yes, type and date: _____)
7. Have you had any prior tests related to today's exam, If so what were the results of the test?_____

Circle region of pain:



Patient Signature:_____ Date:_____

1215 Route 70 West
Suite 1002-1003
Lakewood, NJ 08701

PH# (732) 370-9902
FX# (732) 370-9908

NORTH DOVER
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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 preformed at any outside facilities other than North Dover Radiology. 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 North Dover Radiology located at 1215 Route 70 West, Suite 1002-1003 in Lakewood, 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 North Dover Radiology. Please fax all records to **732-370-9908**.

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

X:_____
SIGNATURE OF PATIENT OR REPRESENTATIVE:
Date:_____/_____/____