

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

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

 Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_  
 Emergency contact person \_\_\_\_\_ phone # \_\_\_\_\_

**INSURANCE INFORMATION**

<b>Is this related to an accident</b>	<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
<b>Date of accident :</b> _____	State Auto Injury occurred in: _____
<b>Attorney Name:</b> _____	Phone# _____
<b>Are you treating with a Chiropractor</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____ Phone: _____

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

<b>SECONDARY</b>		<b>Authorization #</b> _____
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

---

## R A D I O L O G Y

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

---

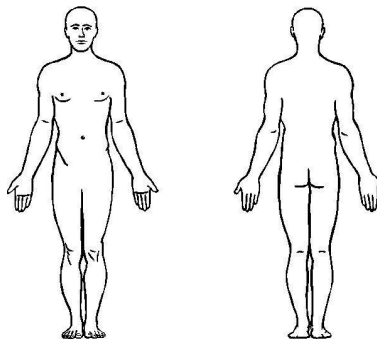
### CLINICAL QUESTIONNAIRE

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

---

## R A D I O L O G Y

1215 Route 70 West  
Suite 1002-1003  
Lakewood, NJ 08701  
(732) 370-9902

**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 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:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_