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

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? __________________________________

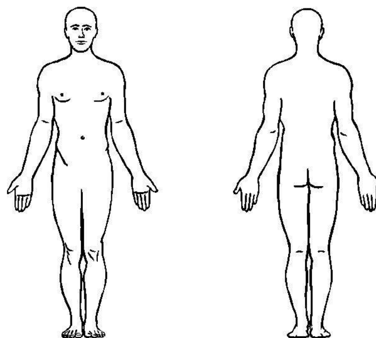
4. Did these complaints/symptoms come on suddenly or gradually? _________________________

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

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 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:_____/_____/____