

## PATIENT PROFILE

### PATIENT INFORMATION

Name: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ Sex: [ ] M [ ] F  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Marital Status: [ ] Married [ ] Single  
Work Phone: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

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### PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] not Employed  
Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_

### EMERGENCY CONTACTS (NAME & PHONE)

(1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_

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### RESPONSIBLE PARTY (Must complete if responsible party is other than insured or patient)

[ ] Same as Patient [ ] Same as Insured Relationship to Patient: \_\_\_\_\_  
Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security: \_\_\_\_\_

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### RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize The Woodlands Open MRI & Imaging Center to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission. \_\_\_\_\_ (initials)

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### ASSIGNMENT OF BENEFITS

In consideration for the services rendered, I hereby irrevocably assign and transfer to The Woodlands Open MRI & Imaging Center, and to any physician providing services, all rights, title and interest, to the benefits payable by any and all third party payors that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow The Woodlands Open MRI & Imaging Center, or those physicians, to pursue any such right of recovery. Even though I have made this assignment, I understand that The Woodlands Open MRI & Imaging Center, has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payors, and I am responsible for payment for any charges not paid for me on my behalf.

\_\_\_\_\_ (initials)

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I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance; therefore, making me fully responsible for any charges incurred.

**Patient/Responsible Party Signature:** \_\_\_\_\_

**CT QUESTIONNAIRE**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Sex M \_\_\_ F \_\_\_ Weight \_\_\_\_\_ Referring Physician \_\_\_\_\_

Please list reason for the CT and details of your symptoms \_\_\_\_\_

Duration of symptoms \_\_\_\_\_ Date of onset of symptoms or injury \_\_\_\_\_

Are your symptoms the result of an injury? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Work related injury? \_\_\_\_\_ Or MVA? \_\_\_\_\_

Please list all prior surgeries \_\_\_\_\_

Have you ever had a study done for this problem at this facility before? YES NO

Have you ever had a CT scan done at another facility? If so, where? \_\_\_\_\_

Please list any prior related diagnostic examinations and date \_\_\_\_\_

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

- |                       |                       |                                |
|-----------------------|-----------------------|--------------------------------|
| <b>Yes</b>            | <b>No</b>             |                                |
| <input type="radio"/> | <input type="radio"/> | Allergies/Hay Fever            |
| <input type="radio"/> | <input type="radio"/> | Lung disease/Asthma/COPD       |
| <input type="radio"/> | <input type="radio"/> | High Blood Pressure            |
| <input type="radio"/> | <input type="radio"/> | Drug or food allergy           |
| <input type="radio"/> | <input type="radio"/> | Kidney Disease/ Kidney Surgery |
| <input type="radio"/> | <input type="radio"/> | Anuria (Inability to urinate)  |
| <input type="radio"/> | <input type="radio"/> | Thyroid disease                |
| <input type="radio"/> | <input type="radio"/> | Multiple Myeloma               |
| <input type="radio"/> | <input type="radio"/> | Sickle Cell disease/Trait      |
| <input type="radio"/> | <input type="radio"/> | Blood Disorders/Leukemia       |
| <input type="radio"/> | <input type="radio"/> | Latex/Adhesive Allergy         |

**Females Only**

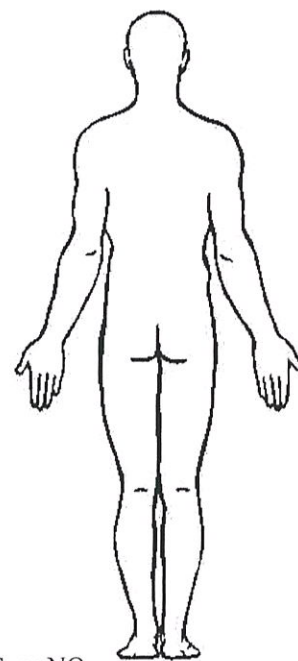
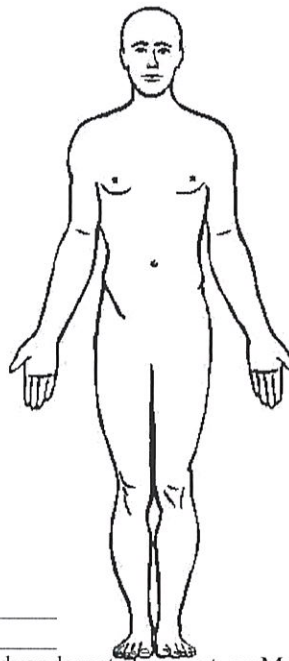
- |                       |                       |                                     |
|-----------------------|-----------------------|-------------------------------------|
| <input type="radio"/> | <input type="radio"/> | Any chance of pregnancy?            |
| <input type="radio"/> | <input type="radio"/> | Are you pregnant or breast feeding? |

**For patients having contrast study:**

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <b>Yes</b>            | <b>No</b>             |   |
| <input type="radio"/> | <input type="radio"/> | History of Cancer? If so, what type? _____      |
| <input type="radio"/> | <input type="radio"/> | Are you diabetic? If yes, list medication _____ |
| <input type="radio"/> | <input type="radio"/> | Kidney problems                                 |
| <input type="radio"/> | <input type="radio"/> | Hypertension                                    |
| <input type="radio"/> | <input type="radio"/> | Are you 60 years old or over?                   |

Please list all Medications: \_\_\_\_\_

**Please shade in the areas where you are having pain or symptoms**



Are you taking Glucophage, Metformin, Glucovance, Glucophage XL, Advandamet, Janumet, or Metaglip? YES or NO

Do you have an appointment for a thyroid uptake and/or pancreas study utilizing nuclear radioisotopes within the next 30 days? Yes or No

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and the MRI procedure that I am about to undergo.

Patient's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Signature of Person Completing Form \_\_\_\_\_ Relationship \_\_\_\_\_

Form Information Reviewed By: \_\_\_\_\_

Front Desk

Technologist