Cypress Women's Imaging  *Imaging Center at Cypress*

Date_____ Referring Physician_____

PATIENT		SUBSCRIBER'S NAME	
FIRST NAME (Please Print) Middle Initial		FIRST NAME (Please Print) Middle Initial	
LAST NAME		LAST NAME	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE ZIP CODE		CITY, STATE ZIP CODE	
HOME PHONE	WORK PHONE	HOME PHONE	WORK PHONE
SOCIAL SECURITY NUMBER	CELL PHONE	SOCIAL SECURITY NUMBER	CELL PHONE
EMPLOYER	OCCUPATION	EMPLOYER	OCCUPATION
SEX MARITAL STATUS		SEX MARITAL STATUS	
BIRTHDATE	AGE	BIRTHDATE	AGE
RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____			
NAME, ADDRESS AND PHONE OF PERSON NOT LIVING WITH YOU, TO CONTACT IN CASE OF EMERGENCY			
GIVE A BRIEF HISTORY OF YOUR ILLNESS:			

INSURANCE INFORMATION	
PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
ADDRESS	ADDRESS
INSURANCE I.D.#	INSURANCE I.D.#
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
IS INJURY A RESULT OF CAR ACCIDENT? _____ (If yes, give name & address of auto carrier in above spaces)	IS X-RAY FOR WORKMANS COMPENSATION?_____ IF YES, GIVE DATE OF INJURY _____

ACKNOLEDGEMENT OF RECEIPT OF OF PRIVACY NOTICE
I acknowledge that I have been offered/received a copy of the Provider's Notice of Privacy Practices with the effective date of April 28, 2003.

_____ has permission to obtain my medical records. Signed Date

AUTHORIZATION TO OBTAIN MEDICAL RECORDS:
I hereby authorize Wichita Radiological Group to obtain any and all of my medical records.

Signed Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby assign and authorize for direct payment for radiological and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance.

Signed Date

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Wichita Radiological Group to release any information acquired in the course of my examination or treatment to my referring doctor and/or insurance company.

Signed Date

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

IMAGING SERVICES PATIENT HISTORY

Name:_____ **Date of Birth:**_____
(print)

Height_____feet_____inches **Current Weight**_____lbs

Date symptoms began:_____
Describe your symptoms below:

_____
_____

Was this a result of an injury? (circle one) Yes No
Have you ever been diagnosed with cancer? (circle one) Yes No
If yes, what type?_____
When?_____
Treatment: Chemotherapy? (circle one) Yes No
Radiation? (circle one) Yes No
Are you diabetic? (circle one) Yes No **Diabetic Medication:**_____
If taking Metformin/Glucophage, do not take for 48 hours after receiving contrast
Have you had a previous study pertaining to this diagnosis: (circle)

CT:	Yes	No	If yes, when and where?_____
MRI:	Yes	No	If yes, when and where?_____
Nuc Med:	Yes	No	If yes, when and where?_____
Ultrasound:	Yes	No	If yes, when and where?_____
X-Ray:	Yes	No	If yes, when and where?_____

List surgeries and dates performed:_____
_____

Do you smoke? (circle one) Yes No
If you quit, when?_____
Do you have a history of multiple myeloma? (circle one) Yes No
Are you pregnant? Yes No
Have only one kidney? Yes No
Kidney disease? Yes No
Previous reaction to contrast? Yes No
Describe Reaction:_____
Iodine Allergy? Yes No
Breast feeding? Yes No
If breastfeeding, dispose of breast milk for 48 hours after receiving contrast

List all medications and dosages:

_____
_____

Patient Signature:_____ **Date:**_____