

Carlsbad Imaging Center
(760) 730-3536

PATIENT PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle: _____
Street Address: _____ Apt# _____
City: _____ State: _____ Zip Code: _____ Driver License (State & #) _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Date of Birth: _____ Sex: Female Male Social Security Number: _____
Marital Status: Single Married Divorced Widowed
Name of Employer or School: _____
Is your condition a result of work comp? Yes No If yes, please give date of injury _____

PATIENT'S PRIMARY INSURANCE INFORMATION

Primary insurance company's name _____
Name of Insured: _____ Date of Birth: _____
Relationship to Insured Self Spouse Child other _____

PATIENT'S SECONDARY INSURANCE INFORMATION

Secondary insurance company's name _____
Insurance Address: _____
Name of Insured: _____ Date of Birth: _____
Relationship to Insured Self Spouse Child other _____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILMS

I, _____, hereby authorize, the above named facility, to release the medical records, diagnostic report and /or film of:

Patient's Name: _____
Date of Birth: _____ Medical Record# _____
Specific exam/exams: _____ Date of service: _____
To: Name: _____ Phone: _____

I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay any fee associated with copying of second set of films.
Applicable Fees: \$15.00 per film

Print Name: _____
Signature: _____ Date: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

AUTHORIZATION

† **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment/diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I am aware that if my account is not paid in full within 90 days from the date of the service, a 30% additional fee will be added to the balance and it will be sent directly to a collection agency and reported to a national credit bureau. The returned checks will also be charged a \$25.00 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. **IF I AM UNINSURED, I am fully responsible for all charges.**

Signature: _____ Date: _____

† **CONSENT FOR MEDICAL TREATMENT/DIAGNOSIS:** I authorize the imaging Center to furnish the necessary medical treatment , or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted in the Imaging Center.

Signature: _____ Date: _____

† **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and center for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of the Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

Signature: _____ Date: _____

IF PATIENT IS UNDER 18: I hereby give my permission for _____ to be treated at the Imaging Center.

In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), **Carlsbad Imaging Center** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center** for patient's privacy.

Signature: _____ Date: _____

Carlsbad Imaging Center
3144 El Camino Real, Suite 100
Carlsbad, CA 92008
Ph.(760) 730-3536 Fax (760) 720-4833

DEXA (Bone Densitometry Exam) QUESTIONNAIRE

MR # :

FIRST NAME: _____

LAST NAME: _____

BIRTH DATE: ___ / ___ / ___

HEIGHT (IN): _____

WEIGHT (LBS): _____ GENDER: FEMALE ___ MALE ___

IF FEMALE PLEASE INDICATE IF POSTMENOPAUSAL _____ PREMENOPAUSAL _____

HISTORY OF NONTRAMATIC FRACTURE:

FEMUR: YES ___ NO ___ **FOREARM:** YES ___ NO ___
HUMERUS: YES ___ NO ___ **PELVIS:** YES ___ NO ___
SPINE: YES ___ NO ___

INDICATIONS: (mark the ones that apply):

ALCOHOLISM _____	AMENORRHEA _____
HYPERTHYROID _____	BILATERAL OVARIEN RESECTION _____
LOW BODY WEIGHT _____	CAUCASIAN _____
CORTICOSTEROID _____	OSTEOPOROTIC _____
EARLY MENOPAUSE _____	FAMILY HISTORY OF FRACTURE _____
HEIGHT LOSS _____	RENAL DISEASE _____
HYPOTHYROID _____	TOBACCO USER _____

WHAT MEDICATION(S) DO YOU TAKE FOR OSTEOPENIA / OSTEOPOROSIS, OR FOR YOUR "BONE"? _____

DOSAGE _____ HOW LONG _____

MARK THE ONES THAT YOU TAKE:

BISPHOSPHONATE ___ CALCITONIN ___ CALCIUM ___ ACTONEL ___

FLUORIDE ___ PTH 1-34 ___ THIAZIDE ___ VITAMIN D ___ FOSAMAX ___

WHEN WAS YOUR LAST DEXA? _____

ARE YOU PREGNANT? : YES ___ NO ___