SPECIALTY IMAGING CENTER
NORTHRIDGE

Today's Date: _____
(Fecha)

Registration Form

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **M.I.:** _____
(Apellido) (Nombre)

Birthdate: _____ **Age:** _____ **Sex:** ❑ M ❑ F
(Fecha de Nacimiento) (Edad) (Sexo)

Address, Apt #: _____ **City:** _____ **State:** _____ **Zip:** _____
(Domicilio, Numero y Calle) (Ciudad) (Estado) (Zona Postal)

Home Phone: _____ **Cell Phone:** _____
(Telefono de Casa) (Telefono de Celular))

Driver's Lic. #: _____ **SSN Patient:** _____
(Numero de Licencia para Cunducir) (Numero de Seguro Social)

Employer: _____ **Telephone:** _____
(Compañia de Trabajo) (Telefono de su Trabajo)

Emp. Address: _____ **City:** _____ **State:** _____ **Zip:** _____
(Domicilio, Numero y Calle)) (Ciudad) (Estado) (Zona Postal)

INSURANCE INFORMATION

Primary Ins.: _____ **Subscriber #:** _____ **Group #:** _____
(Seguanza Primaria) (Numero de a siguranza) (Numero de Grupo)

Insured Name: _____ **Relationship:** _____ **Phone:** _____
(Nombre de Su Esposo(a), o Persona Responsible) (Relacion) (Telefono)

Insured Lic. #: _____ **SSN Insured:** _____
(Numero de Licencia para Cunducir) (Numero de Seguro Social)

Employer: _____ **Telephone:** _____
(Compañia de Trabajo) (Telefono de su Trabajo)

Emp. Address: _____ **City:** _____ **State:** _____ **Zip:** _____
(Domicilio, Numero y Calle)) (Ciudad) (Estado) (Zona Postal)

MEDICAL INFORMATION

Doctor who referred you to our office: _____
(Nombre del doctor quien lo mando)

Was there an injury? ❑ Yes ❑ No **Date of Injury** _____ **Type of Injury:** ❑ WORK ❑ PERSONAL
(Fue un Herida) (Fecha de Herida) (Tipo de Herida) (Trabajo) (Personal)

SIGNATURES

I attest that the information provided on this form is true to the best of my knowledge. I understand that ALL fees are due from ALL PATIENTS as services are rendered, unless prior arrangements have been made with this office. I understand that Insurance Authorization does not guarantee payment and I am responsible for all charges. Please Return this form with your Driver's License and Insurance Card.

(Atesto que toda la informacion en esta forma es real y verdadera de acuerdo a mi conocimiento. Entiendo que todos las tarifas de los servicios son desponibles al tiempo que los servicios son realizados. Entiendo que autorizacion del seguro no garantiza el pago y que yo soy responsable por todos los cargos. Favor de regresar esta forma con su lisencia de conductor y tarjeta de su seguro medico.)

_____ _____
Signature of Patient **Date**

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CT SCREENING AND HISTORY

PATIENT NAME: _____ **D.O.B.**_____ **WEIGHT:** _____

Have you been here before? YES ❑ NO ❑ When?: _____

Is there a possibility that you may be pregnant? YES ❑ NO ❑ **Date of last menstrual cycle:** _____

Are you breast feeding? YES ❑ NO ❑

Have you had anything to eat in the last four hours? YES ❑ NO ❑

Have you had severe or life-threatening reactions to food, medication, or bug bites? YES ❑ NO ❑

If yes, please explain: _____

_____

Do you have any allergies? YES ❑ NO ❑

If yes, please explain:_____

_____

Have you had contrast injections before? YES ❑ NO ❑

Have you had any reactions to iodine contrast? YES ❑ NO ❑

If yes, please explain what reaction you had: _____

Did you have to be resuscitated? YES ❑ NO ❑

Have you ever been diagnosed with cancer/serious illness? YES ❑ NO ❑

Have you had chemotherapy? YES ❑ NO ❑

Have you had radiation therapy? YES ❑ NO ❑

Do you have any of the following conditions?

Asthma? YES ❑ NO ❑ **Lung disease?** YES ❑ NO ❑

Shortness of breath? YES ❑ NO ❑ **High Blood Pressure?** YES ❑ NO ❑

Heart Disease? YES ❑ NO ❑ **Kidney Disease/dysfunction?** YES ❑ NO ❑

Do you smoke or did you ever smoke? YES ❑ NO ❑ **How many years/packs per day?** _____**years /** ____**packs**

When did you stop smoking? _____

Currently on Dialysis? YES ❑ NO ❑

Diabetic? YES ❑ NO ❑ **IF YES are you taking: Glucophage ❑ Metformin ❑ Glucovance ❑**

What type of symptoms are you having?_____

_____

Please list previous surgeries: _____

_____

SIGNATURE: _____ **TODAY'S DATE:** _____

19871 Nordhoff Street
Northridge CA 91324
(818)349-5050 (T)
(818)349-5052 (F)

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PATIENT CONSENT FORM TP USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By signing this form, you are granting consent to Northridge Specialty Imaging Center to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our "Notice of Privacy Practices" provides more detailed information about how may use and disclose this protected health information. You have a legal right to review out "Notice of Privacy Practices" before you sign this consent and we encourage you to read it in full.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operation. We are not required by the law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Northridge Specialty Imaging Center may disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals relevant to their involvement in your care or the payment for your Northridge Specialty Imaging Center also may notify a family member or another person who is responsible for your care of your location and general health condition. Please initial on the following to indicate your choice regarding such disclosures.

- I do not object my personal health information being disclosed to a family member friend, or another individual in my care.

- I object to my personal health information being disclosed to a family member friend, or another individual in my care.

Patient Name :_____ Date:_____

Signature of Patient or Patient Representative:_____