Patient Registration & X-Ray Screening Form

Please Print Patient Information:

First Name: _____ M.I. _____ Last Name: _____

DOB: _____ Male / Female Height: _____ Weight: _____ SSN: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

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

Referring Physician: _____ Physician Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Please select one of the following:
Insurance _____ / Uninsured / Workers' Compensation / Other _____

Please Print Patient History:

Reason for Exam: _____

Signs/Symptoms: _____ Duration: _____

Medical History: _____

Surgical History: _____

Have you had prior imaging exams related to your current symptoms? No / Yes

Date: _____ Prior Exam: _____ Outside Facility: _____
Date: _____ Prior Exam: _____ Outside Facility: _____
Date: _____ Prior Exam: _____ Outside Facility: _____

CONSENT: I attest the above information is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form. I have also informed the technologist that **I am not pregnant at this time.**

Signature of Person Completing Form: _____ Date: _____
Relationship to Patient: □ Self □ Spouse □ Guardian

Screening Form Reviewed by Technologist: _____ Date: _____
(print first initial & last name)