NEBRASKA HEALTH IMAGING	Exam Date and Time:	MRN/Jacket:	Patient Registration

Name:
Address: **City, State, Zip:**
Home Phone: **Mobile Phone:**
Email: **Date of Birth:**
Race: **Gender:** **Marital Status:**
SSN:
Referring Physician:

Emergency Contact Information

Name: **Contact Phone:**

Insurance

Primary Insurance Plan Name:
Policy #: **Group #:**

Secondary Insurance Plan Name:
Policy #: **Group #:**

Relationship to Insured

Insured Name: **Relationship to Patient:**
Insured DOB:

Auto Accident or Worker's Compensation Information

Is this injury due to accident? **Yes** ☐ **No** ☐ **If yes, what type of Accident?**
Accident Date: **Accident State:**

Patient Name:	MRN/Jacket #:

By signing below, I agree to the following for outpatient radiology care provided by NEBRASKA HEALTH IMAGING

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, NEBRASKA HEALTH IMAGING may use and disclose my protected health information for treatment, payment and health care operations as explained in the . Notice of Privacy Practices. I also authorize release of my protected health information to NEBRASKA HEALTH IMAGING the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?

Yes ☐ No ☐

MEDICAL RECORDS CAN BE RELEASED TO:

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Financial Responsibility

With this consent, I authorize NEBRASKA HEALTH IMAGING and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, NEBRASKA HEALTH IMAGING may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it may decline to provide treatment to me.

Signature: _____ **Date:** _____

Printed Name: _____

MRI/CT EXAMINATION QUESTIONAIRE

NAME: _____ **DOB:** _____

ARE YOU CLAUSTROPHOBIC? _____

BRIEFLY DESCRIBE YOUR PAIN AND INDICATE HOW LONG YOU HAVE HAD THESE SYMPTOMS: _____

_____

_____

WERE YOU INJURED? IF SO, EXPLAIN AND GIVE THE DATE: _____

_____

_____

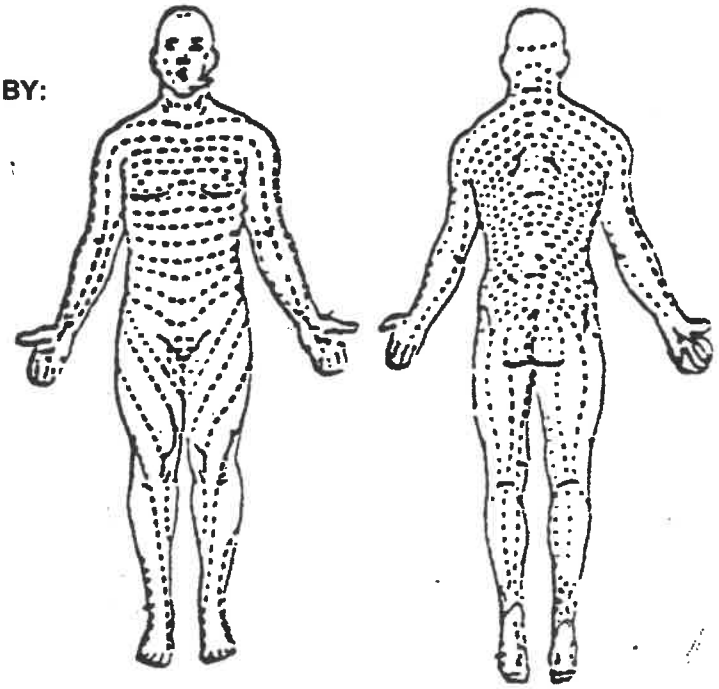
HAVE YOU HAD PRIOR SURGERY TO THIS AREA? IF SO, DESCRIBE AND GIVE THE DATE: _____

_____

_____

PLEASE INDICATE THE AREAS OF YOUR SYMPTOMS BY:

P = PAIN,
T = TINGLING,
N = NUMBNESS,
W = WEAKNESS



I attest that the above information is correct and true to the best of my knowledge.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Last revision 111604

Nebraska Health Imaging

CT HISTORY FORM

Patient Name: _____

DOB: _____ Age: _____Height: _____ Current weight: _____

Have you had a previous imaging study related to this problem? □ **Yes** □ **No**

If yes. What exam? □ **CT** □ **MRI** □ **Ultrasound** □ **X-ray** □ **Other** What Facility? _____

PERSONAL HISTORY

Have you ever had a allergic reaction to injected CT or x-ray contrast (x-ray dye) □ **Yes** □ **No**

If yes, explain: _____

□ **Yes** □ **No** Heart Disease

□ **Yes** □ **No** High Blood Pressure

□ **Yes** □ **No** Asthma/Other Lung Disease

□ **Yes** □ **No** Kidney Disease/ Kidney Failure

□ **Yes** □ **No** Diabetes

□ **Yes** □ **No** Dialysis

□ **Yes** □ **No** Do you take Metformin hydrochloride (Glucophage, Glucovance, Avandement, Metaglip, or Fortamet?)

□ **Yes** □ **No** Allergies If yes, please specify: _____

□ **Yes** □ **No** Surgeries If yes, please specify: _____

□ **Yes** □ **No** Cancer If yes, please specify: _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? □ **Yes** □ **No** Date of last period: _____

ACKNOWLEDGEMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

Patient/ Guardian Signature: _____ Date: _____

Technologists Signature: _____ Date: _____