207 B Sidney Baker Street S
Kerrville, Texas 78028
830-496-3357

Date:

PATIENT NAME	GENDER	DOB	AGE
MAILING ADDRESS	Email	SSN	Marital Status
CITY, STATE ZIP	HOME PHONE	CELL PHONE	WEIGHT
EMERGENCY CONTACT	RELATIONSHIP		PHONE #
PRIMARY INSURANCE	MEMBER ID #		GROUP #
SECONDARY INSURANCE	MEMBER ID #		GROUP #
POLICY HOLDER	ADDRESS		SSN

Y N cardiac pacemaker/pacing wires
Y N respiratory disease
Y N Metal removed from eyes
Y N claustrophobic
Y N artificial heart valve
Y N metal rods, pins, screws
Y N HX of cancer/Multiple Myloma
Y N eye implants or cataract surgery
Y N bullets/shrapnel
Y N HX of Kidney problems
Y N IUD/Pessary/Diaphragm
Y N ear implants
Y N are you pregnant
Y N are you breastfeeding

Y N are you on dialysis
Y N body piercings (other than ears
Y N brain aneurysm clips
Y N history of diabetes
Y N hearing aids
Y N allergy to contrast/gadolinium
Y N dentures/partials
Y N prior brain surgery
Y N any type of prosthesis
Y N neurostimulator
Y N stents or shunts
Y N liver disease
Y N drug infusion device
Y N is this scan work related/auto/personal injury

YOUR REFERRING PHYSICIAN WILL BE THE ONE TO GIVE YOU THE RESULTS OF YOUR EXAM

Office Use

Registration ID:

Accession Number:

MEDICAL HISTORY

Patient Name:______________________________ Technologist Name:________________________

What complaints or symptoms led you to seek medical help?

____

Was this an injury: Yes or no Date of injury ________________________________

Describe the injury.

____

Have you ever had surgery to this area? Yes or No Have you ever had an MRI done on the area? Yes or No

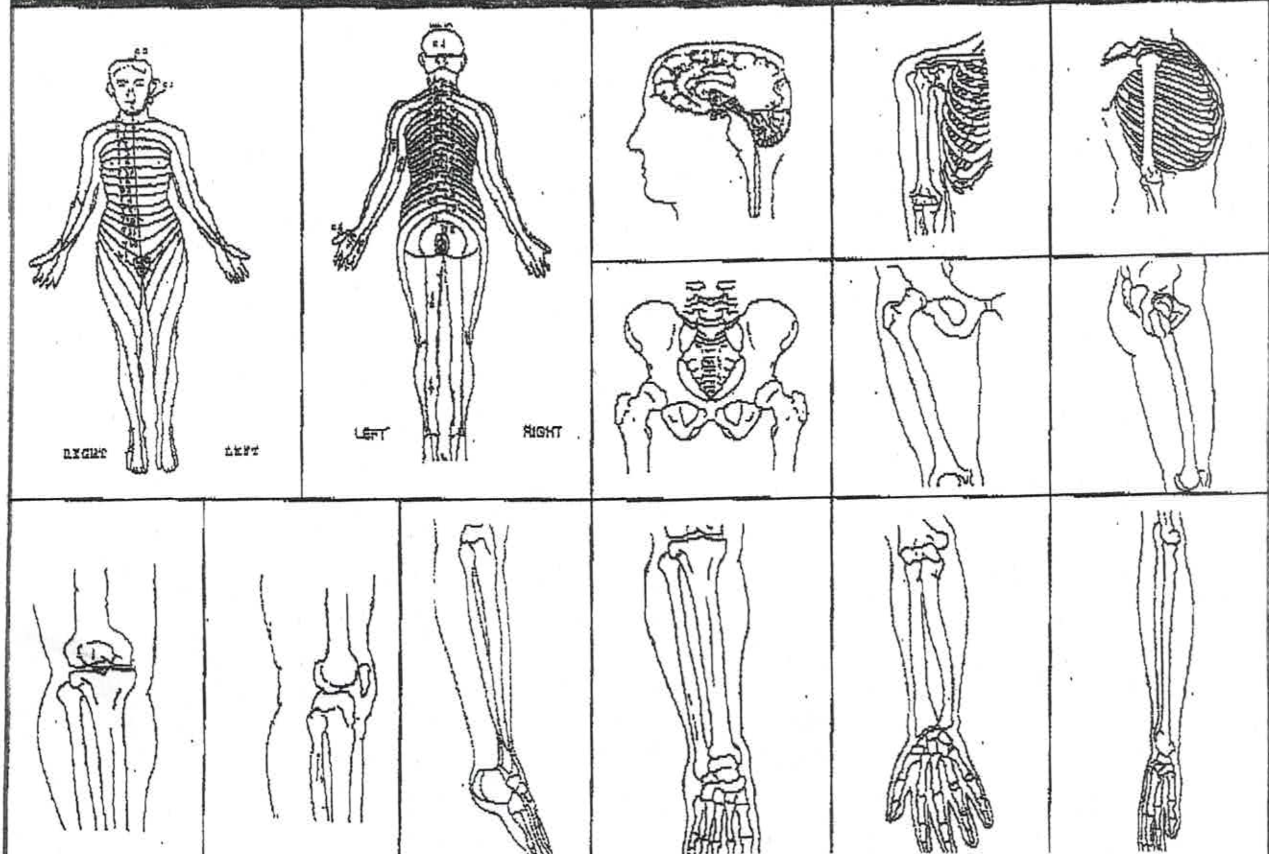
If yes to either, what type and when:____

Do you have a personal history of cancer Yes or No If yes to either what type__________________

Symptoms (check all that apply)

	Numbness		Tingling		Burning		Dizziness
	Weakness		Headache		Nausea/Vomiting		Blurred Vision
	Swelling		Mass or Bump		Fever/chills		incontinence
	Clicking Joint		Decreased ROM		Catching sensation		Stiffness
	Pain (describe						
Technologies Notes:							

USE APPROPRIATE DIAGRAM TO SHOW LOCATION OF SYMPTOMS



ATTENTION PATIENTS WITH MEDICARE INSURANCE

Y OR N Have you made any changes to your Medicare coverage? If so please explain -

____

Y or N are you currently in a skilled nursing facility?

Name of Facility:______________________________

Phone: ______________

*IF YOU ARE IN A SKILLED NURSING FACILITY, PLEASE NOTIFY THE FRONT DESK *

Assignment of Benefits

I attest that the information above is correct to the best of my knowledge. I give consent to the examination ordered by my physician, According to the information, I acknowledge that I have given **Stone Imaging** the right to file to my insurance for payment of services rendered and I agree to pay any balance remaining on the account after my insurance has paid or denied payment. I understand that I must pay any deductible and/or coinsurance at the time of service, that the quote for deductible and/or coinsurance is only an estimate, and that a prior authorization from the insurance is not a guarantee of their payment of my claim. I acknowledge that when my insurance is involved, **Stone Imaging** is contractually obligated to collect co-payments, co-insurance, and deductible as outlined by my insurance carrier. I authorize release of my medical information to and from physicians, nursing facilities, and/or health care agencies to which I may be referred or transferred. I also understand that a $25 service fee will be charged for all returned checks. I agree, in addition to the amount owed for my current visit, I will be responsible for the fee charged by collection agency for cost of collections, If such action becomes necessary. ***THIS IS A NOTIFICATION THAT CERTAIN SERVICES THAT ARE DEEMED NECESSARY BY YOUR PHYSICIAN MAY NOT BE REIMBURED BY YOUR INSURANCE COMPANY, INCLUDING MEDICARE. I ALSO ACKNOWLEDGE THE NOTICE OF PRIVACY PRATICE AVAILABLE IN THE OFFICE.**

Authorization for Use or Disclosure of Health Information

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under federal health privacy law and described below:

I understand that I may revoke this authorization at any time by notifying **Stone Imaging** in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by **Stone Imaging** prior to receiving my revocation.

HIPPA AUHORIZATION

The report containing your results will automatically be sent to your ordering physician following your exam **STONE IMAGING** cannot release any information to any individual other than you unless listed below. This includes picking up reports and/or CD's. ID will be required for pick up. Please list any family or friends you might send for pick up of these items. It is not necessary to list ordering doctor. Your referring physician will give you your results. I ______________________ authorize **STONE IMAGING** to release my medical information to the following parties listed below until I revoke this release in writing.

Please print

Name and relationship:______________________________

Name and relationship:______________________________

Signature of patient:______________________ signature of representative______________

DOB______________ Date______________ Print name of representative______________