PATIENT REGISTRATION FORM

****OFFICE USE ONLY****

TODAY'S DATE: _____ **MR#: _____**

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: (_____) _____-_____ **CELL PHONE#: (_____) _____-_____**

DATE OF BIRTH: _____ **SEX: ☐ MALE ☐ FEMALE**

ETHNIC GROUP:

- ___ ASIAN
- ___ AFRICAN AMERICAN
- ___ HISPANIC/LATINO
- ___ MIDDLE EASTERN
- ___ NATIVE AMERICAN
- ___ PACIFIC ISLANDER
- ___ OTHER
- ___ WHITE

RACE:

- ___ AMERICAN INDIAN
- ___ ASIAN
- ___ BLACK/AFRICAN-AMERICAN
- ___ HAWAIIAN-PACIFIC ISLANDER
- ___ WHITE
- ___ OTHER

LANGUAGE:

- ___ ARABIC
- ___ CANTONESE
- ___ ENGLISH
- ___ HEBREW
- ___ JAPANESE
- ___ KOREAN
- ___ MANDARIN
- ___ RUSSIAN
- ___ SPANISH

SOCIAL SECURITY #: _____-_____-_____

E-MAIL ADDRESS: _____

TYPE OF EXAM: _____

REASON FOR THE EXAM: _____

************************************INSURANCE INFORMATION************************************

Name of Insurance: _____ Member ID _____ Group # _____

Secondary Insurance: _____ Member ID _____ Group # _____

PRIMARY POLICY HOLDER (please check one)**: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER**

If different than the patient, please complete the following:

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

************************************EMERGENCY INFORMATION************************************

In case of emergency, please notify:

NAME: _____

RELATIONSHIP TO PATIENT: _____

TELEPHONE #: (_____) _____-_____

PATIENT'S SIGNATURE: _____ DATE: _____

MAIN STREET RADIOLOGY
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Bayside, New York 11358
FAX: (718) 224-0978

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Bayside, New York 11361
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Downtown Flushing Office
136-25 37th Avenue
Flushing, New York 11354
FAX: (718) 661-1305

Western Queens Office
72-06 Northern Blvd.
Jackson Heights, NY 11372
Tel: (718) 907-2383
Fax: (718) 907-2384

DATE: _____ **Name:** _____

Address: _____

Weight: _____

Telephone Number: Home: ( ) _____ **Work:** ( ) _____

Do you have any allergies to food, if so list?_____

If yes, please describe reactions: _____

Do you have any allergies to medication, if so list?_____

If yes, please also list reaction: _____

Please list the medications taken regularly: _____

Please check if you have any of the following:

	Y	N		Y	N		Y	N
Asthma	☐	☐	**Heart Disease**	☐	☐	**Hay Fever**	☐	☐
Sickle Cell	☐	☐	**Diabetes**	☐	☐	**Kidney Disease**	☐	☐

If you are on dialysis, what was the date of your last dialysis:_____

Are you pregnant? **Yes**____ **No**____

Have you had a previous CT scan? **Yes**____ **No**____

If yes where: _____ **For what reason:**_____

What problems are you having now? _____

For how long: _____ **Which side? Left**____ **Right**____

Why are you having this CT scan? _____

Have you had any surgery on the area to be scanned? Yes____ **No**____

List any surgical procedures and approximate dates: _____

Have you ever had chemotherapy or radiation therapy? Yes____ **No**____

If so, when and where? _____

SIGNED_____**DATE**_____

Updated 9/26/16

Name: _____ Date: _____

Your imaging procedure requires the administration of x-ray dye/contrast (these are 2 commonly used names for the same thing). This injection will help the physician to interpret the exam.

Have you ever had the injection of x-ray dye/contrast? Yes____ No____

If yes, have you ever had, as a result of the injection of contrast any of the following:

Hives	**Yes____**	**No____**
Shortness of breath	**Yes____**	**No____**
Fainting or collapse	**Yes____**	**No____**

X-ray dye/contrast is administered by injection through a small needle placed in your vein. During the administration of the x-ray dye/contrast you may experience a feeling of warmth which is normal and expected.

Normally, the administration of x-ray dye/contrast is quite safe; however, there is a slight risk of an allergic reaction.

- **Some patients (1 out of 1,000) develop sneezing and/or hives.**
- **In rare cases (1 out of 100,000) a patient death has occurred due to an allergic reaction to the x-ray dye/contrast.**
- **The physicians and staff at Main Street Radiology are trained to respond to any situation that may develop.**

I have read and understand the above information and agree to have the CT scan and the injection of dye/contrast.

***Signature _____Relationship to Patient_____**
Date_____

***NOTE: If the patient is under eighteen (18) years old, the authorization of the parent or guardian must be obtained, unless the patient is married or the parent of a child.**
IF YOU HAVE ANY FURTHER QUESTIONS PLEASE SPEAK TO THE RADIOLOGIST.

Updated 06/06/2017

ACKNOWLEDGEMENT

I, the undersigned, acknowledge the receipt of a complete copy of Main Street Radiology's HIPAA PRIVACY NOTICE concerning the use or disclosure of my protected health information ("PHI") and consent to the release of any medical information about me (and any others for whom I can give consent to the extent permitted by law) by Main Street Radiology's health care providers and its staff to any other heath care providers involved in caring for me (or for others for whom I can give consent) to carry out diagnosis and treatment.

With your permission, we can communicate medical information to you or a designee by fax, e-mail and voicemail. Please sign and provide the appropriate information below allowing Main Street Radiology to do so on your behalf.

- ☐ Cell Phone Voicemail _____
- ☐ Work Phone _____
- ☐ Fax _____
- ☐ Unencrypted E-Mail _____

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

EMPLOYEE INITIALS_____