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:** _________________

Updated 11-18-2016

NUCLEAR MEDICINE PATIENT REGISTRATION FORM

Last Name: ________________________ First Name ____________________MR#________
(office use only)

Height: ____________________________ Weight: _________________________

ALLERGIES:_____________________________

1. Why is the doctor sending you for this exam? ____________________________

____

2. Do you have a history of cancer ? YES_____ NO_____

a.) If YES, what type?__________________ When where you first diagnosed?______
b.) Did you have surgery?______________ When?______________
c.) Did you have Radiation therapy?______ When?______________
d.) Did you have Chemotherapy?_________ When?______________

3. Othe known medical conditions:____

____

4. Medications you are currently taking:____

____

a.) When last taken?______________

5. Do you currently have a specific complaint ? (i.e. pain, numbness, pressure)

____

6. Any chance you may be pregnant? YES _____ NO _____

Patient Signature:______________________________________ Date:_______________

Modified 5/3/2018

QUESTIONNAIRE FOR THYROID UPTAKE AND SCAN

LAST NAME: ___________________________ FIRST NAME: ________________________MR#__________
(office use only)

Today's Date: _____________ Date of Birth:_________________

1. **Any chance you may be pregnant? _____________**
   Date of last menstrual period: ________________

2. **Have you have any recent exams where you have been injected with a radiological dye or contrast? _________________**
   If yes, what type : Xray____IVP____ Gallbladder____
   Myelogram______ Angiogram_____ CT-Scan________

3. **Are you currently taking any medications?____________ If so please list:_________________**
   ____

4. **When was the last time you took any medications?__________________________________**

5. **Are you taking any of the following?**
   Vitamins_________________ Birth Control Pills________
   Antihistamines__________ Cough Medicine_________

6. **Have you ever had thyroid surgery?___________________When?_______________________**

7. **Have you ever had a thyroid scan before______________When?________________________**
   Where?_______________________ Reason for previous thyroid scan?_________________
   ____

9. **Have you ever received radiation treatments to your face or neck before?_________**
   ____

10. **Have you recently experienced the following:**
    Weight Gain ____________ Weight Loss____________
    Tremors________________ Palpitations_____________
    Intolerance to hot or cold__________Any changes in hair, skin or nail texture?____________

Modified 5/3/2018

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_____________