# 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

# 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**

MAIN STREET RADIOLOGY
TEL: (718) 428-1500 www.mainstreetradiology.com

# PET SCAN QUESTIONAIRE

**NAME**_____ **DATE**_____

1. **Have you ever had a PET Scan before?** **YES** **NO**

   If yes, which facility? _____When?_____

2. **Have you had a CT Scan before?** **YES** **NO**

   If yes when was the most recent test performed? _____

3. **Why are you having a PET scan today?**

   _____

4. **Do you presently have or have had a history of cancer?** **YES** **NO**

   If yes, what type? _____

   When did you have your last surgery or biopsy?_____

   Where was it performed? _____

5. **Have you had chemotherapy?** **YES** **NO**

   If yes, when was your last treatment? _____

6. **Have you had radiation therapy?** **YES** **NO**

   If yes when was your last treatment? _____

7. **Have you had immunotherapy?** **YES** **NO**

   If yes when was your last treatment? _____

8. **Have you ever taken Neupogen, Epogen, or Leukogen?** **YES** **NO**

   If yes, when was the last dose? _____

9. **Are you a diabetic?** **YES** **NO**

   If yes, when was your last dose of insulin or oral medication? _____

10. **Do you have a history of sarcoidosis?** **YES** **NO**

11. **When was the last time you ate or drank?** _____

12. **Are you pregnant?** **YES** **NO**

# 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_____**