Sacramento IMAGING

PATIENT INFORMATION

NAME: _____ MRN: _____ Last 4 digits of SSN: _____
SEX: _____ DOB: _____ AGE: _____

(Check the preferred contact method below)
☐ HOME PHONE: _____ ☐ WORK: _____
☐ CELL: _____ ☐ EMAIL: _____

HOME/MAILING ADDRESS: _____
CITY/STATE: _____ ZIP: _____

EMERGENCY CONTACT

FIRST NAME_____MI_____LAST_____

RELATIONSHIP_____PHONE_____EMAIL _____

EHR INFORMATION

ETHNICITY: ☐ Hispanic or Latino ☐ Armenian
☐ White ☐ Black African American
☐ Asian ☐ American Indian or Alaska Native

PREFERRED LANGUAGE: _____

SMOKER: ☐ Current everyday smoker ☐ Former smoker ☐ Never smoked

REFERRING DOCTOR:_____ PHONE: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EXPLAIN CURRENT INJURY, COMPLAINT OR SYMPTOMS: _____

IS THIS VISIT FOR TESTING DUE TO AN AUTO ACCIDENT? YES NO DATE:_____

1. **PRIMARY** INSURANCE CO:_____
INSURED'S NAME_____INSURED'S DOB _____
INSURED'S SS#_____YOUR RELATION TO INSURED _____

2. **SECONDARY** INSURANCE CO:
INSURED'S NAME_____INSURED'S DOB _____
INSURED'S SS#_____YOUR RELATION TO INSURED _____

I, the undersigned have insurance with the above listed company(s) and assign directly to **Sacramento Imaging** all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance company.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. **Medicare authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Sacramento Imaging** for any service furnished to me by that physician. I authorize any holder of medical information about me to release to the health care financing administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the hcfa form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer agency shown. In Medicare assigned, the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
Patient Signature Print Name Date

PATIENT HEALTH HISTORY

Patient name:_____**Date:**_____

Your answers on this form will help your technician get an accurate history of your medical concerns and conditions. If you can't remember specific details, please provide your best guess.
REVIEW OF SYMPTOMS: Please check mark any persistent symptoms you have had in the past few months. Read through every section and check mark "no problems" if none of the symptoms apply to you.

GENITOURINARY
___Leaking urine
___Blood in urine
___Increased urination
___Discharge penis or vagina
___Other
___No Problems

INFECTIONS
___MRSA
___Hepatitis
___HIV/AIDS
___Tuberculosis
___Other
___No Problems

NEUROLOGICAL
___Headaches
___Memory loss
___Fainting/Dizziness
___Numbness/Tingling
___Other
___No problems

EARS/NOSE/THROAT
___Nosebleeds/Trouble swallowing
___Frequent sore throat/Hoarseness
___Hearing loss/Ringing in ears
___Other
___No problems

RESPIRATORY
___Cough/Wheezing
___Shortness of breath
___Altered breathing
___Other
___No problems

GENERAL
___Unexplained weight loss
___Unexplained fatigue
___Fever/Chills
___Other
___No problems

GASTROINTESTINAL
___Heartburn/Reflux/Indigestion
___Blood/Bowel movement changes
___Constipation
___Other
___No problems

MUSCULOSKELETAL
___Neck pain
___Back pain
___Muscle/Joint pain
___Other
___No problems

HEMATOLOGICAL/ LYMPHATIC
___Swollen glands
___Easy bruising
___Other
___No problems

CARDIOVASCULAR
___Chest pain/discomfort
___Palpitations
___Other
___No problems

ENDOCRINE
___Heat or cold sensitivity
___Other
___No problems

SKIN
___Rash/Itching
___Other
___No problems

WOMEN ONLY
Are you pregnant?____**YES,**____**NO,** If **NO**, when was your last menstrual cycle?_____
___Problems with menstruation _____Other _____**No problems**

_____
Patient Signature Print Name Date