Homer Glen
OPEN MRI & IMAGING

Patient Registration

CT Scan | Please print clearly or fill in on your device

PATIENT INFORMATION

Last name | First name | M.I. | Date of birth (MM/DD/YYYY)

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street address

City | State | ZIP code

Cell phone | Home phone | Email

Social Security # | Referring physician

INSURANCE

Primary insurance | Member ID | Group #

Policy holder name | Policy holder date of birth | Relationship to patient

EMERGENCY CONTACT

Name | Relationship | Phone

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Homer Glen Open MRI & Imaging. I understand that I am responsible for any charges not covered by my insurance. I also authorize the release of any medical information needed to process my insurance claims.

Patient or guardian signature | Date

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CT Questionnaire

CT scan | Contrast screening

Exam being performed

Height

Weight

Please explain your symptoms in detail

List any surgeries in the area of interest for today's exam

Are you, or could you be, pregnant? ☐ Yes ☐ No ☐ N/A

If female, first day of last menstrual period

CONTRAST SCREENING

1. Are you over the age of 60? ☐ Yes ☐ No

2. Are you diabetic? ☐ Yes ☐ No

3. Do you have a history of kidney disease, kidney failure, a single kidney, sickle cell disease or multiple myeloma? ☐ Yes ☐ No

> If you answered yes to question 1, 2 or 3, you need a recent lab test (BUN and creatinine, or GFR) from within the past 60 days. Please get a copy of the results from your physician and bring it to your appointment. If the results were abnormal (high), the labs must be redrawn before the CT can be done with contrast.

4. Are you allergic to iodine or X-ray contrast dye? ☐ Yes ☐ No

If yes, what kind of reaction did you have?

> If you are allergic to iodine, your ordering physician must be told. The physician may do the test without contrast (no labs needed) or pre-medicate you. Pre-medication is a 13-hour prep that your physician orders through your pharmacy; we can fax the prep instructions to your physician if needed.

5. If you are allergic to iodine, have you been pre-medicated for today's exam? ☐ Yes ☐ No ☐ N/A

6. Did you bring a copy of your most recent lab work? ☐ Yes ☐ No ☐ N/A

7. Other medications you are allergic to

8. Current prescribed medications

Patient or guardian signature

Date

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Contrast Consent

CT Scan | Consent for contrast media tests and procedures

Patient name

Date of birth

Date

Procedure to be performed

Reason for procedure

PLEASE ANSWER EVERY QUESTION

Are you, or could you be, pregnant? ☐ Yes ☐ No ☐ N/A

If female, first day of last menstrual period

Do you have diabetes, asthma, hay fever, sickle cell disease, myeloma or known thyroid disease? ☐ Yes ☐ No

Are you allergic to any drugs or foods, or have you had a reaction to a previous contrast injection for X-ray, CT or MRI? ☐ Yes ☐ No

Do you take any medications, including non-prescription drugs (for example Glucophage or metformin)? ☐ Yes ☐ No

If yes to any question, please explain

> If you answered yes to any of the questions above, you have a higher than normal risk of an adverse reaction to the contrast used in your exam. Please tell the technologist before your exam begins.

RISKS AND CONSENT

The most common reactions to contrast are mild and pass quickly, such as nausea, vomiting, flushing or a general feeling of warmth. Less often, chills, fever, sweating, headache, dizziness, weakness, wheezing, rash, swelling, cramps or a change in blood pressure may occur, and rarely severe or life-threatening reactions have happened. Contrast may also affect kidney function. These risks have been explained to me, and I understand that the benefit of the exam may outweigh them. I understand I have the right to change my decision or withdraw consent at any time.

I consent to the administration of contrast as my physician or the staff of Homer Glen Open MRI & Imaging consider necessary or appropriate for my exam.

Patient or guardian signature

Date

If signed by a representative, name and relationship to patient

Date

FOR OFFICE USE

Person obtaining consent

IV location

Contrast used and amount

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Privacy Practices Acknowledgment

Health Insurance Portability and Accountability Act (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in my care.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have been offered the Notice of Privacy Practices, and I understand that I may contact Homer Glen Open MRI & Imaging at any time to request a current copy. The Notice is also available at homerglenimaging.com/privacy.html.

I understand that I may request in writing how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations by Homer Glen Open MRI & Imaging.

Patient name (print)

Date of birth

Patient or guardian signature

Date

If signed by a representative, name and relationship to patient