ID #: _____
(office use only)

CHESAPEAKE MEDICAL IMAGING

Patient Name: _____
First **MI** **Last**

Address: _____
Street/City **State/Zip**

Birthdate: _____ **Home Phone:** _____**Cell Phone:** _____

Primary Care Physician: _____**Personal Email:** _____

Weight _____ (lb) **Height** _____ (ft/in)

Gender: □ Male □ Female **Last Menstrual Cycle** _____

Are you pregnant or breastfeeding? □ **Yes** □ **No**

Ethnicity/Race: Are you Hispanic? □ Yes □ No □ White □ Black or African American □ Asian □ other □ Decline to state

Smoking Status: □ Daily □ Occasionally □ Former □ Never **Primary Language:** □ English □ Spanish □ other

Personal history of cancer? □ YES □ NO If yes, what type and when? _____

List prior surgeries: _____

List current medication(s): □ None _____

Latex Allergy: □ YES □ NO **Medication Allergies**: □ None _____

Do you have an aneurysm clip or a pacemaker?	□	Yes	□	No
Do you have a hearing aid or implant?	□	Yes	□	No
Do you have any metal in your body?	□	Yes	□	No

Please indicate your next scheduled visit with your referring doctor or specialist (circle one):

TODAY TOMORROW WITHIN ONE MONTH TO BE DETERMINED

Please state the reason for your procedure(s) today. What are your symptoms? *VERY IMPORTANT*

_____ _____
Date Started

_____ _____
Date Started

FOR ABDOMINAL STUDIES ONLY: Please tell us where your pain is (circle one)

RIGHT UPPER LEFT UPPER RIGHT LOWER LEFT LOWER

Payment of Benefits/Medical Release Authorization:
I authorize the release of my medical records to my physician. I authorize payment of benefits, as determined by the company. I may still be responsible for any amount not paid by my insurance company in the event that the payments made are not reasonable and customary. I authorize any health care provider, insurance company, organization, employer or hospital, to release any information requested with regard to my medical records or processing of my claim. I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and I have had an opportunity to ask questions regarding the information on this form.

Patient/Guardian Signature _____ Date _____

Date Updated _____ Initials _____ Date Updated _____ Initials _____