ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Sex: ___Male _____Female

HOME ADDRESS _____

MAILING ADDRESS _____

PRIMARY CARE PHYSICIAN _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER - INFORMATION:

CURRENT EMPLOYER _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE NUMBER _____

SPOUSE - INFORMATION:

SPOUSE'S NAME _____ SPOUSE'S DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S EMPLOYER _____

SPOUSE'S EMPLOYER PHONE NUMBER _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

PRIMARY INSURED NAME (IF OTHER THAN PATIENT) _____ RELATIONSHIP _____

PRIMARY INSURED DOB: _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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BONE DENSITY QUESTIONNAIRE

Name:_____ Date:_____

Referring Physician:_____

Race: Asian_____ White_____ Black_____ Other_____

Date of Birth:_____ Height:_____ Weight:_____

Personal History

Is there any chance you may be pregnant? yes___ no___

Do you have any metal in spine and/or hips? yes___ no___

Have you ever broken (or fractured) a bone? Yes___ No___ If yes, at what age? _____

Previous Bone Density Yes___ No___ When_____

Do you smoke? Yes___ No___ Quantity_____

Do you drink alcohol? Yes___ No___ Quantity_____

Have you lost height (become shorter)? Yes___ No___

Have you been diagnosed with Osteoporosis or Osteopenia? Yes___ No___

Family history of Osteoporosis (mother, grandmother, sister, aunt)? Yes___ No___

Family history of fractures? Yes___ No___

Medical History

Hysterectomy: No___ Partial (uterus only)___ Full___

What age did you go through menopause? _____

Do you take hormones or birth control pills? Yes___ No___ If yes, how long?_____

Do you take medication for thyroid problems? Yes___ No___ Medication_____

Have you had kidney failure? Yes___ No___ Are you on dialysis? Yes___ No___

Do you have Crohn's Disease or Ulcerative Colitis? Yes___ No___

Do you have Rheumatoid Arthritis? Yes___ No___

Do you have times when you fall for no specific reason? Yes___ No___

Do you take steroids now? Yes___ No___ If yes, for how long?_____

Have you ever taken steroids? Yes___ No___ If yes, for how long?_____

Medication	Yes	No	Duration
Boniva/Ibandronate			
Miacalcin/Calcitonin			
Actonel/Risedronate			
Evista/Reloxifene			
Forteo/Teripatatide Injection			
Fosamax			
Calcium			
Vitamin D			
Seizure Medication			
Epilepsy Medication			
Medication to control convulsions			
Reclast Infusion			

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PATIENT CONSENT FORM

By signing this form, you are granting consent to Advanced MRI and Imaging to use and disclose your protected health information for the purpose of treatment, payment, and health care operations as well as any ordered testing or imaging

Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our notice of privacy practices before you sign this consent.

Our notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from our office.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your original consent.

_____

Patient name (please print above)

_____ _____

Patient Signature Date

_____

Witness name (please print above)

_____ _____

Witness signature Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

_____ Spouse

_____ Significant other

_____ Family Member (name: _____)

_____ Caregiver

_____ Answering Machine

_____ Send artificial, prerecorded, or automated calls and test messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

_____

Signature of Patient (of parent/guardian or minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR OFFICE USE ONLY

Print Name: _____

Signature: _____ Date: _____