

ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870

Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form

(PAGE 1 OF 2)

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Height _____ Sex: ☐ Male ☐ Female

HOME ADDRESS _____

MAILING ADDRESS _____

PRIMARY CARE PHYSICIAN _____

Patient Home Ph _____ Patient Cell Phone _____ Email _____

AREA TO BE EXAMINED / TYPE OF EXAMINATION: _____

DIAGNOSIS OR CLINICAL SUSPICION _____

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? ☐ Yes ☐ No

If yes: What _____ When _____ Where _____

Have you ever smoked? If yes for how long? _____ How many packs a day? _____ If you are an ex-smoker, how long ago did you quit? _____

Cancer ☐ Yes ☐ No

If yes: What type _____ Body Part _____

Radiation therapy: ☐ Yes ☐ No Chemotherapy: ☐ Yes ☐ No

Are you **pregnant**? ☐ Yes ☐ No Date of last menstrual period: _____

Patient or Legal Representative Signature: _____ Date: _____

Witness or Interpreter Signature : _____ Date: _____

Technologist Signature: _____ Date: _____

Additional comments: _____

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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/Teriparatide Injection			
Fosamax			
Calcium			
Vitamin D			
Seizure Medication			
Epilepsy Medication			
Medication to control convulsions			
Reclast Infusion			

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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 the 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.

X

Patient Name (Please Sign)

(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.

X

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: _____

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Advance MRI & Imaging is committed to the health and safety of all our patients, visitors and team members. We are conducting screening for COVID-19. If you answer yes to any of the questions below, you will be given further instructions.

We now require all patients to be wearing a mask at all times during your visit to the center.

1. Do you currently have a cough, fever, shortness of breath or difficulty breathing? **YES / NO**
2. Have you travelled outside highlands county within the past 14 days? **YES / NO**
3. If yes where?
4. Have you had close contact with someone with known or suspected COVID-19 in the last 14 days? **YES / NO**
5. Have you been tested for COVID-19 within the past 14 days? **YES / NO**
If YES: When _____ What were the results? _____

Patient signature