



Today's Date: _____
(Fecha)

Registration Form

PATIENT INFORMATION

Last Name: _____ <small>(Apellido)</small>	First Name: _____ <small>(Nombre)</small>	M.I.: _____	
Birthdate: _____ <small>(Fecha de Nacimiento)</small>	Age: _____ <small>(Edad)</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <small>(Sexo)</small>	
Address, Apt #: _____ <small>(Domicilio, Numero y Calle)</small>	City: _____ <small>(Ciudad)</small>	State: _____ <small>(Estado)</small>	Zip: _____ <small>(Zona Postal)</small>
Home Phone: _____ <small>(Telefono de Casa)</small>	Cell Phone: _____ <small>(Telefono de Celular)</small>		
Driver's Lic. #: _____ <small>(Numero de Licencia para Conducir)</small>	SSN Patient: _____ <small>(Numero de Seguro Social)</small>		
Employer: _____ <small>(Compañia de Trabajo)</small>	Telephone: _____ <small>(Telefono de su Trabajo)</small>		
Emp. Address: _____ <small>(Domicilio, Numero y Calle)</small>	City: _____ <small>(Ciudad)</small>	State: _____ <small>(Estado)</small>	Zip: _____ <small>(Zona Postal)</small>

INSURANCE INFORMATION

Primary Ins.: _____ <small>(Seguanza Primaria)</small>	Subscriber #: _____ <small>(Numero de a siguranza)</small>	Group #: _____ <small>(Numero de Grupo)</small>	
Insured Name: _____ <small>(Nombre de Su Esposo(a), o Persona Responsable)</small>	Relationship: _____ <small>(Relacion)</small>	Phone: _____ <small>(Telefono)</small>	
Insured Lic. #: _____ <small>(Numero de Licencia para Conducir)</small>	SSN Insured: _____ <small>(Numero de Seguro Social)</small>		
Employer: _____ <small>(Compañia de Trabajo)</small>	Telephone: _____ <small>(Telefono de su Trabajo)</small>		
Emp. Address: _____ <small>(Domicilio, Numero y Calle)</small>	City: _____ <small>(Ciudad)</small>	State: _____ <small>(Estado)</small>	Zip: _____ <small>(Zona Postal)</small>

MEDICAL INFORMATION

Doctor who referred you to our office: _____
(Nombre del doctor quien lo mando)

Was there an injury? Yes No Date of Injury _____ Type of Injury: WORK PERSONAL
(Fue un Herida) (Fecha de Herida) (Tipo de Herida) (Trabajo) (Personal)

SIGNATURES

I attest that the information provided on this form is true to the best of my knowledge. I understand that ALL fees are due from ALL PATIENTS as services are rendered, unless prior arrangements have been made with this office. I understand that Insurance Authorization does not guarantee payment and I am responsible for all charges. Please Return this form with your Driver's License and Insurance Card.

(Atesto que toda la informacion en esta forma es real y verdadera de acuerdo a mi conocimiento. Entiendo que todos las tarifas de los servicios son desponibles al tiempo que los servicios son realizados. Entiendo que autorizacion del seguro no garantiza el pago y que yo soy responsable por todos los cargos. Favor de regresar esta forma con su lisencia de conductor y tarjeta de su seguro medico.)

Signature of Patient

Date



CT Screening and History

PATIENT NAME: _____ D.O.B.: _____ WEIGHT: _____

HAVE YOU BEEN HERE BEFORE? YES NO If YES, then when? _____

HOW DID YOU HEAR ABOUT US? _____

Please answer the following

YES NO Are you pregnant? YES NO Are you breast feeding?
Date of last menstrual cycle: _____

YES NO Have you had anything to eat in the last 4 hours?

YES NO Have you had severe or life-threatening reaction for food, medication, or bug bites?
If YES, please explain: _____

YES NO Do you have any allergies?
If YES, please explain: _____

YES NO Have you had any contrast injections before?

YES NO Have you had any reactions to iodine contrast?

YES NO Have you eve been diagnosed with cancer or serious illness?

YES NO Have you had Chemotherapy?

YES NO Have you had radiation therapy?

Do you have any of the following conditions?

YES NO Asthma? YES NO Lung Disease?

YES NO High Blood Pressure? YES NO Heart Disease?

YES NO Shortness of Breath? YES NO Kidney Disease/Dysfunction?

YES NO Smoker? How long? _____ YES NO Currently on Dialysis?

YES NO Diabetic?
If YES, are you taking: Glucophage Metformin Glucovance

What type of symptoms are you having? _____

Please list any previous surgeries: _____

Signature: _____ Date: _____



CT CONTRAST CONSENT

Patient Name: _____

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE FACILITY PERSONAL AT ONCE.

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the image to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling, of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic condition, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking any Glucophage, are pregnant or breast feeding, you **MUST** inform the technologist.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CAT scan to be the best diagnostic test for you after evaluating your symptoms and medical conditions.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Patient / Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



Coronary CT Angiography (CCTA)

Patient Preparation

Before the study

- No caffeine (in any form) 12 hours prior to the exam
- Nothing to eat or drink 4 hours prior to the exam, please take required medication with a small amount of water, if necessary
- Bun / Creat w/in 60 days

Upon arrival

- We ask that patients arrive 1 hour prior to the study
- An IV catheter will be placed in an appropriate vein as determined by the nurse or radiologist

Beta Blockers

For patients with beta blocker approval by referring MD on CT request form:

- 50 mg po metoprolol the night before the test
- 50 mg po metoprolol on the day of the test 1 hour before the scheduled time

After the study

- Patient must drink plenty of fluids

Alerts

- No Glucophage / Metformin (diabetic patients) 48 hours after in injection