WOODBRIDGE RADIOLOGY

Chart #______________ APPT BY: ________

Patient Name____ DOB____________________

Address____ APT# _____ City_______________ Zip __________

Phone #_____________________ SS#________________ Email: (appointment alerts)________________________

Work status	☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐Student
Marital status	☐ Single ☐ Married ☐ Widowed ☐ Divorced

How were you referred to our office

☐ Referring Dr ☐ Internet ☐ Zoc Doc ☐ Returning Patient ☐ ETC._______

When is your follow up appointment with your doctor regarding this study? ________________________________

Employer_________________________________ Employer's Address _________________________________

Emergency contact person _________________________________phone #_______________________

INSURANCE INFORMATION

Is this related to an accident	☐ Yes ☐No ☐ NA If yes, ☐ Auto, ☐ W.Comp. ☐ Other
Date of accident : _______________	State Auto Injury occurred in: ____________

Attorney Name: ____	Phone#_________________________
Are you treating with a Chiropractor ☐ Yes ☐ No	Name: ________________Phone: _______________

PRIMARY **Authorization #** ________________________________

Name Insurance:	Id #	Group #
Phone #	Insurance Address	Adj Info
Subscriber name	D.O.B/ S.S.#	Relationship

SECONDARY **Authorization #** ______________________________

Name Insurance:	Id #	Group #
Phone #	Insurance Address	Adj Info
Subscriber name	D.O.B/ S.S.#	Relationship

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare patients) and all other third party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand if my account is sent to collection for payment, I will incur additional charges (a minimum of 25%) on the amount sent; this applies to co payments as well. This is for today's service and any future services at Woodbridge Radiology. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

This facility will provide a locker in which you must store your personal items and valuables. Please lock these items in the area provided, and bring the key with you into the scan room for security. Woodbridge Radiology will not accept liability for any personal belongings.

I hereby authorize Woodbridge Radiology to deliver my imaging studies to the referring physician or specialist at his/her request. I understand that these studies are a permanent part of my medical record. I hereby release Woodbridge Radiology from any and all legal responsibility or liability that may arise from release of these films. I have been offered a copy of the HIPPA compliance and understand and agree to its terms.

_______________________________________ _________________________

Signature **Today's date**

All patients/legal guardians must REVIEW, SIGN and DATE all paperwork.

WOODBRIDGE RADIOLOGY

CT QUESTIONNAIRE

APPT BY:_________

APPOINTMENT DATE_________________________**TIME**_______________________________

Do You Have A Follow-up Appt. with your Doctor? ___________ ***When?***__________

Patient's Name _________________________________ **DOB**________________ (**Circle)** Male/Female

Type of Scan_______________________________________R/O___________________________

Referring Physician _____________________________ **Phone #**____________________________

Weight __________ **Age** _______ ***(*Any patient with diabetes, kidney failures or over 60 must have blood work)**

Any history of smoking	☐ YES ☐ NO ☐ N/A	
Are you allergic to iodine or contrast dye	☐ YES ☐ NO ☐ N/A	If so, what happens ____________________________
Are you allergic to shellfish	☐ YES ☐ NO ☐ N/A	If so, what happens ____________________________
Do you have any allergies	☐ YES ☐ NO ☐ N/A	
Do you have any history of asthma or difficulty breathing	☐ YES ☐ NO ☐ N/A	
Are you diabetic/Blood work needed	☐ YES ☐ NO ☐ N/A	If yes, what medication do you take ___________________________
Are you on Dialysis	☐ YES ☐ NO ☐ N/A	IF SO PATIENT MUST SCHEDULE DIALYSIS AFTER SCAN
Do you have any kidney/renal disease	☐ YES ☐ NO ☐ N/A	
Do you have any history of cancer	☐ YES ☐ NO ☐ N/A	If so, what happens ____________________________
Is there a possibility you might be pregnant	☐ YES ☐ NO ☐ N/A	LAST LMP ______________________
Are you able to walk without assistance	☐ YES ☐ NO ☐ N/A	
Patient over 60 MUST they have blood work	☐ YES ☐ NO ☐ N/A	FRONT DESK MUST OBTAIN BLOODWORK (LABS: BUN, GFR, CREATINE)
Have you had any previous exams of the same body part	☐ YES ☐ NO ☐ N/A	

NOTES/SPECIAL INSTRUCTIONS:

Attachments: ☐ Prior Exam ☐ Blood work ☐ Script

Patient/Guardian Signature: ____ **Date:** _________________

PATIENT: Please review the information provided at the time of scheduling. Your Signature will verify its accuracy

Front Desk Only: Date: ____________ ☐ **CONFIRMED** ☐ **LEFT MESSAGE** ☐ **NO ANSWER**

For Contrast studies: ☐ **instructed patient to drink water**

3T MRI • 1.2T Open MRI • Low Dose CT • Ultrasound • Digital X-Ray

CLINICAL QUESTIONNAIRE

Name:________________________________ Date:__________________

Allergies: ____

1. Why has your doctor sent you for this test? Did she/he give you a specific diagnosis?
   ____
   ____
   ____

2. Please describe what specific complaints/symptoms have been most bothersome to you?
   ____
   ____
   ____

3. How long have you had these complaints/symptoms? __________________________________

4. Did these complaints/symptoms come on suddenly or gradually? _________________________

5. These complaints/symptoms have:

   ________improved ________remained the same ________worsened

6. Have you had any previous surgery related to today's exam? ____Yes ____No
   (If Yes, type and date: ____)

7. Have you had any prior tests related to today's exam, If so what were the
   results of the test?____

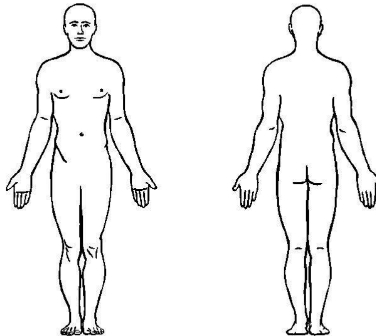
8. Do you have any history of any cancer? ____Yes ____No

9. Do you have a history of smoking? ____Yes ____No

FEMALE PATIENTS:

1. Are you pregnant? ____Yes ____No ____ N/A
2. Date of Last Menstrual Period____________________

Circle region of pain:



Patient Signature:______________________________ Date:____________________

530 Green Street
Iselin, NJ 08830

PH# (732) 326-1515
FX# (732) 326-1522

WOODBRIDGE
RADIOLOGY

530 Green Street
Iselin, N.J. 08830
(732) 326-1515

PATIENT NAME:____

DOB:_____/_____/_____ **PATIENT SOCIAL SECURITY #:**____-____-_____

REVIEW OF OUTSIDE FILMS POLICY:

Please make available to the front office any prior imaging films, CD's, and reports at the time of your appointment. This pertains solely to any exams preformed at any outside facilities other than Woodbridge Radiology. Please be advised that if you fail to bring your prior exam at the time of your appointment there will be a $100.00 "Review of Outside Film" charge for any comparison performed after your original appointment date.

DISC AND FILM RELEASE:

I hereby release Woodbridge Radiology located at 530 Green Street, Iselin, NJ from any and all legal responsibility or liability that may arise from release of records. For any additional disc or films a fee will be charged. The fee for a disc will be $25.00 and films will cost $75.00.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby request you to release my medical records to/from Woodbridge Radiology. Please fax all records to 732-326-1522.

Name of Referring Doctor or Organization:________________________
Ph#:________________________ FX#:___________________________

X:____
SIGNATURE OF PATIENT OR REPRESENTATIVE:
Date:_____/_____/____