

Chart # _____

APPT BY: _____

Patient Name _____ DOB _____

Address _____ APT# _____ City _____ Zip _____

Phone # _____ SS# _____ Email: (appointment alerts) _____

Work status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
How were you referred to our office <input type="checkbox"/> Referring Dr <input type="checkbox"/> Internet <input type="checkbox"/> Zoc Doc <input type="checkbox"/> Returning Patient <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes, <input type="checkbox"/> Auto, <input type="checkbox"/> W.Comp. <input type="checkbox"/> Other
Date of accident : _____	State Auto Injury occurred in: _____
Attorney Name: _____	Phone# _____
Are you treating with a Chiropractor <input type="checkbox"/> Yes <input type="checkbox"/> 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

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?

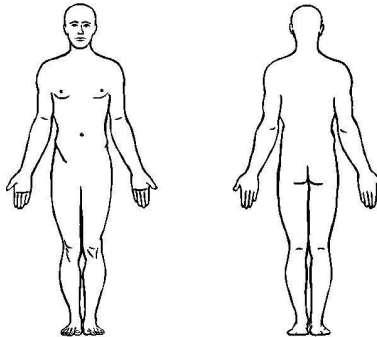
2. Please describe what specific complaints/symptoms have been most bothersome to you?

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: _____



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 performed 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: ____ / ____ / ____