Please Print & Answer All Questions.

Mink Radiologic Imaging Registration Patient Profile

Registered Location:_____

Social Security Number:_____

First Name: _____

Last Name: _____

Address 1: _____

City: _____ **Zip code:** _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Email: _____

Date Of Birth: _____

Gender: _____

Primary Insurance Carrier Name: _____

Policy Number: _____

Group Name: _____

Group Number: _____

Pre-Certification Phone Number: _____

Secondary Insurance Carrier Name: _____

Policy Number: _____

Group Name: _____

Group Number: _____

Relationship To Insured

Relationship: _____

First Name/Last Name: _____

Date Of Birth: _____

Gender: _____

I acknowledge that to the best of my knowledge, this infomation is current and correct.

Signature: _____ Date:_____

Please Print & Answer All Questions.

Mink Radiologic Imaging

Pt Name:
Date of Birth:
Referring Physician:

Contrast Consent Form

Your doctor has requested a CT scan ("CAT scan"), which is a special x-ray exam that produces cross-sectional images of your body. It requires the injection of an iodine-containing contrast agent which significantly improves the detection of abnormalities. The contrast agent is given through a small catheter placed into a vein, usually near your elbow or hand. A contrast injection is normally safe; however, any injection carries a slight risk of injury to a vein or the adjacent artery or nerve. Less than 1% of patients will experience a reaction to the contrast agent itself, most of which are mild such as hives or itching. The staff of our department is trained to treat these reactions. The incidence of very serious or fatal reactions is extremely rare.

Certain patients are at a higher risk for experiencing reactions from contrast injections and they include:
1) those who have already had a moderate or severe allergic reaction which required treatment 2) those with severe allergies or asthma
3) those with severe or incapacitating heart disease
4) those with severe kidney disease, especially caused by diabetes.

If you believe you are in one of the above categories, please notify a member of our staff. If you have any questions, please don't hesitate to ask our staff.

I have read the above information and have had any questions answered.

History:
Clinical:
Technologist:

Signature (Parent or Guardian)
Date Signed:
Relationship, if signed by person other than patient:

MR Room (Metal) Questionnaire

*Please Print & Answer All Questions.

NAME: _____

Have you ever had surgery? Please list below.

_____

_____

PLEASE LIST YOUR WEIGHT

Weight: _____

☐ Yes ☐ No Personal history of cancer?

☐ Yes ☐ No Are you diabetic?

☐ Yes ☐ No History of kidney disease?

☐ Yes ☐ No Have you ever been a machinist, welder, or metalworker?

☐ Yes ☐ No Have you ever been hit in the face or eye with a piece of metal (including metal shavings, slivers, bullets or BBs?

☐ Yes ☐ No Have you ever had a piece of metal removed from your eye?

☐ Yes ☐ No **Are you pregnant, possibly pregnant, or breast feeding?**

Do you have any of these items in your body?

☐ Yes ☐ No Pacemaker, wires, or defibrillator (If yes, see Front Desk)

☐ Yes ☐ No Brain aneurysm clip (If yes, see Front Desk)

☐ Yes ☐ No Ear implant

☐ Yes ☐ No Eye implant (Not including cataract lenses)

☐ Yes ☐ No Electrical stimulator for nerves or bone

☐ Yes ☐ No Magnetic implant anywhere

☐ Yes ☐ No Infusion pump

☐ Yes ☐ No Coil, filter, or wire in blood vessel

☐ Yes ☐ No Artificial limb or joint

☐ Yes ☐ No Implanted catheter or tube

☐ Yes ☐ No Artificial heart valve

☐ Yes ☐ No Penile prosthesis

☐ Yes ☐ No Shunt and or a stent

☐ Yes ☐ No False teeth, retainers, or magnetic braces

☐ Yes ☐ No Surgical clips, staples, wires, mesh, or stitches

☐ Yes ☐ No Ortho devices (plates/screws/pins /rods/wires)

Information Concerning Gadolinium Contrast Material

As part of your examination, the radiologist may deem it advisable to give you an I.V. injection of a contrast agent containing gadolinium. This injection may help the physician more accurately diagnose your condition. Although gadolinium contrast agents have been used safely in millions of cases, minor reactions (i.e. headaches and/or nausea) occur in about 2% of patients, whereas serious or life-threatening reactions have been reported in about one in 400,000 patients.

☐ Yes ☐ No Have you ever had an MRI exam with gadolinium contrast material?

☐ Yes ☐ No If yes, did you have an allergic reaction to the gadolinium contrast material?

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Patient, Parent, or Guardian)

_____

Date Signed: _____

Please Print For Your Files.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures:

Treatment: Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by our staff members.

Payment: Your health information may be used to seek payment from your health plans, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities of Mink Radiologic Imaging. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit and written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information may be used by our staff to send you appointment reminders.