ULTRASOUND PROCEDURE QUESTIONNAIRE

PATIENT NAME________________________________ DATE: ____________

EXAM ORDERED____________________ REFERRING PHYSICIAN________________

SYMPTOMS____________________ DOB: ____________ AGE: __________

____

______________________________ SEX M F

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

Y N ABDOMINAL PAIN
Y N PELVIC PAIN
Y N PAIN IN LIMB(S)
ARM OR LEG
Y N SWELLING IN LIMB(S)
ARM OR LEG

Y N LACK OF COORDINATION
Y N CHEST PAIN
Y N IRREGULAR HEARTBEAT/PALPITATIONS
Y N SYNCOPE/FAINTING
Y N SHORTNESS OF BREATH

PLEASE LIST ALL ALLERGIES BELOW

1.______________________ 3.______________________

2.______________________ 4.______________________

PLEASE LIST ALL MEDICATIONS

1.______________________ 3.______________________

2.______________________ 4.______________________

PLEASE LIST ALL SURGERIES

1.______________________ 3.______________________

2.______________________ 4.______________________

HAVE YOU HAD PREVIOUS CT, XRAYS, OR MRI RELATED TO THIS PROBLEM?
IF YES, WHEN & WHERE: CT________________________________
XRAYS________________ MRI________________________

PATIENT'S INITIALS____________ LAST MENSTRUAL PERIOD________________

Office Use
Received by:________
Entered by:________

PATIENT PROFILE

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City: ____________ State: ______ Zip: ______

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

EMAIL: ______________________________

Patient ID#: __________ Sex: [ ]M [ ]F

Date of Birth: ______________________________

Social Security #: ______________________________

Marital Status: [ ] Married [ ] Single

Referring Physician: ______________________________

Primary Care Physician: ______________________________

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed

Employer: ______________________________

Phone: ______________________________

EMERGENCY CONTACTS (NAME & PHONE)

(1)______________________________

(2)______________________________

(3)______________________________

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

[ ] Same as Patient [ ] Same as Insured

Name: ______________________________

Address: ______________________________

City, State, & Zip: ______________________________

Drivers License #____________________ State_____

Relation to Patient: ______________________________

Employer: ______________________________

Phone: ______________________________

Date of Birth: ______________________________

Social Security#: ______________________________

PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your insurance.)

Name of Insured: ______________________________

Name of Insurance Company: ______________________________

Insurance Phone #: ______________________________

Insured Employer: ______________________________

Relation to Patient: ______________________________

Insured SS#: ______________________________

Policy Group #: ______________________________

Insured Date of Birth: ______________________________

IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES / NO (IF YES, PLESE COMPLETE BELOW.)

SECONDARY INSURANCE

Name of Insured: ______________________________

Name of Insurance Company: ______________________________

Insurance Phone #: ______________________________

Insured Employer: ______________________________

Relation to Patient: ______________________________

Insured SS#: ______________________________

Policy Group #: ______________________________

Insured Date of Birth: ______________________________

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

Please tell us how you were referred to our office: ___friend ___doctor ___location ___internet ___insurance ___other:

Patient/Responsibility Party Signature: ______________________________