

Appointment Date:

Last Name	First Name	MI	Date of Birth	Male	Female
Street Address				Height	Weight
City	Zip Code	Preferred Email Address			
Social Security #	Home Phone	Work Phone	Cell Phone		
Employer Name					
Insured's Name		Insured's Employer		Relationship to Patient	
Insurance		ID#			
Secondary Insurance		Secondary ID#		Secondary Insured's DOB	

Are you here as the result of a car accident?	Yes		No
	<input type="checkbox"/>		<input type="checkbox"/>
Are you here as the result of a work related			
	<input type="checkbox"/>		<input type="checkbox"/>

- Why did you choose Zwanger-Pesiri Radiology?**
- A) Friend/Family Member Recommendation
 - B) Doctor Referral
 - C) Advertisement (Radio, Newspaper, Etc.)
 - D) Convenience (Hours, location, etc.)

Patient Name _____ Date _____

Yes No

Does your insurance have a deductible?

Do you have an HSA or HRA plan?

If yes, we need a copy of your debit card.

Authorization for Treatment: I hereby consent to treatment by the radiologist and other medical staff for all local anesthetics, radiologic tests and/or procedures as deemed necessary by myself and the Zwanger-Pesiri Radiology staff:

I am aware that additional charges may be incurred if a diagnostic mammogram is deemed necessary. I understand that according to my particular insurance plan, this may or may not be covered.

Authorization for Release of Information and Assignment of Benefits: I hereby assign to Zwanger-Pesiri Radiology, LLP those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with testing performed and treatment rendered. I request that payment of authorized benefits be made directly to Zwanger-Pesiri Radiology on my behalf. I fully understand that I am financially responsible for **any** and **all** amounts not otherwise paid by my insurance carrier:

I certify that the information on this form given by me for payment under Title XVIII (Medicare) is correct and complete. I authorize holder of medical or related information about me to be released to the Health Care Financial Administration (HCFA) and/or other health care coverage entity, any information needed of this or any related healthcare claim in writing or verbally. I further understand and agree to pay for services or amounts due when denied as not covered by Medicare or any other health insurance plans

I hereby authorize release of my films, images, reports and medical records as needed for subsequent medical care. In event of positive findings I authorize release of my results to my referring and treating physicians for their records.

I acknowledge that I have been provided with a copy of the Zwanger-Pesiri Radiology's Notice of Privacy Practices.

In addition, I give the right for Zwanger-Pesiri Radiology, LLP to contact the following person(s) to discuss medical treatment and/or billing information:

Persons(s) Relationship Phone#

This authorization will remain in effect unless changed by me, while I am a patient of Zwanger-Pesiri Radiology, LLP.

Pregnancy Denial Statement

Women age 12-55 (except ultrasound)

I hereby attest that there is **NO** possibility that I am pregnant.

Patient signature

Patient Name _____ Date _____

Cardiac Stress Questionnaire

Past Medical History

- | | | | |
|--------|--|--------|-----------------------|
| Yes/No | Heart Attack | Yes/No | Chest Pain |
| Yes/No | Heart Valve Problems | Yes/No | Hypertension |
| Yes/No | Stroke | Yes/No | Diabetes |
| Yes/No | Congestive Heart Failure | Yes/No | Heart Muscle problems |
| Yes/No | Heart Rhythm problems | Yes/No | Lung Disease |
| Yes/No | Pacemaker | Yes/No | Asthma or wheezing |
| Yes/No | Defibrillator | | |
| Yes/No | Shortness of breath with exercise? | | |
| Yes/No | Chest discomfort or pain with exercise? | | |
| Yes/No | Difficulty walking? (arthritis or vascular disease of the legs) | | |
| Yes/No | Have you had any recent radiation or chemotherapy? | | |
| Yes/No | Do you currently smoke? If yes, how many packs per day? _____ | | |
| Yes/No | Are you an ex-smoker? If yes, how long ago did you quit? _____ | | |
| Yes/No | Do you use inhalers or bronchodilators? Yes/No Did you bring them? | | |
| Yes/No | Do you have any allergies? If yes, list and describe symptoms: | | |
- _____

Have had prior stress testing?

- Yes/No Regular exercise stress
Yes/No Stress Echocardiogram
Yes/No Thallium Stress Test

Have you had any invasive cardiac testing or treatment?

- Yes/No Angiogram/Cardiac Catheterization When? _____
Yes/No Angioplasty/Stent placement? When? _____
Yes/No Electrophysiology Studies/Ablation? When? _____
Yes/No Coronary Artery Bypass Surgery? When? _____
Yes/No Valve replacement surgery? When? Type? _____

List all your medications: _____

What medications did you take today? _____
When is the last time you ate and/or drank anything? _____
When did you last have caffeine? (coffee, tea, cola, chocolate) _____

I understand that payment is due at the time of service and that I am financially responsible for ANY and ALL amounts not otherwise paid by my insurance carrier.

I UNDERSTAND THAT MY ACCOUNT WILL BE SUBJECT TO AN ADDITIONAL \$15.00 PROCESSING FEE EACH MONTH IF PAYMENT IS NOT RECEIVED BY THE DUE DATE INDICATED ON MY BILLING STATEMENT.

I further attest that the information I have provided on these **forms** are true to the best of my knowledge

Patient or Legal Guardian Signature _____
Date

Please sign here

