

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**

Are you here as the result of a work related

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.

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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#
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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 _____

Ultrasound Questionnaire

All Ultrasound Patients

Reason for this ultrasound exam, list symptoms: _____

Yes/No Have you had this exam before? If yes, where and when? _____

Yes/No Do you have any pain? Where? _____

Yes/No Do you have any tenderness to touch? Where? _____

Yes/No Do you have any abnormal lumps or masses? Where? _____

Yes/No Have you had any surgery? If yes, list type and date: _____

Yes/No Have you had any organs removed? If yes, which? _____

Yes/No Do you have any medical conditions? If yes, list and describe treatment : _____

Yes/No Do you currently have cancer? If yes, what type and treatment: _____

Yes/No Did you previously have cancer? If yes, what type and treatment: _____

Yes/No Recent abnormal blood tests? List type and results: _____

Yes/No Have you had any recent injury? When and what type? _____

Obstetrical Ultrasound Patients Only

Date of Last Menstrual Period (LMP) ? _____

Yes/No Do you have spotting or bleeding (female pelvic patients)?

Please sign here



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