NYMI
NEW YORK MEDICAL IMAGING ASSOCIATES
Drs. Maklansky, Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky

PATIENT'S NAME: _____ DOB: _____DATE:_____

CT SCAN PATIENT INFORMATION SHEET

To maximize the value of the examination you are about to have, it helps us to have as much information as possible. Therefore, please answer the following questions:

1. Why did you visit the doctor who sent you for this examination? _____

2. What symptoms (if any) are you experiencing? _____

3. Do you have or have had a diagnosis of cancer? ☐ **YES** ☐ **NO** If yes, what area of the body? _____

4. Have you ever had any surgical procedures? ☐ **YES** ☐ **NO** If yes, please provide the details along with the date of surgery. _____

5. Have you had any previous radiology or endoscopy exams pertaining to your current symptoms? ☐ **YES** ☐ **NO**

If yes, please provide the following information: _____

EXAM:_____WHERE:_____WHEN:_____

6. Have you had any previous CT SCANS/PET SCANS or other scans pertaining to this exam? ☐ **YES** ☐ **NO**

If yes, please provide the following information:

EXAM: _____WHERE: _____WHEN:_____

7. Have you ever smoked? ☐ **YES** ☐ **NO**

8. Do you smoke now? ☐ **YES** ☐ **NO**

NOTE: IF YOU BROUGHT OLD FILMS WITH YOU, PLEASE NOTIFY THE RECEPTIONIST

1. Do you have any allergies? (Including iodine/shellfish/seafood) ☐ **YES** ☐ **NO**

If yes, please write down what you are allergic to: _____

2. Have you received intravenous contrast previously? ☐ **YES** ☐ **NO**
3. Have you had an adverse reaction to intravenous contrast? ☐ **YES** ☐ **NO**

For female patients: **Are you pregnant?** ☐ **YES** ☐ **NO Date of last menstrual period:**_____

PLEASE CHECK BOX(ES) THAT APPLY TO YOU:

☐ **4.** Kidney failure?
☐ **5.** On dialysis?
☐ **6.** Single kidney?
☐ **7.** Asthma?
☐ **8.** Sickle cell disease?
☐ **9.** Heart disease? ☐ **9A. Pace Maker?**
☐ **10.** Arrhythmia?
☐ **11.** Angina pectoris?
☐ **12.** Recent heart attack?
☐ **13.** A diagnosis of **Myeloma**?
☐ **14.** Diabetes?
☐ **15.** Taking Glucophage/Glucovance/Metformin?
☐ **16. Pulmonary** hypertension?
☐ **17.** Respiratory failure?
☐ **18.** Pregnant?
☐ **19.** Breast feeding?

PLEASE READ AND SIGN BELOW:

I, the undersigned patient, hereby authorize the doctors to perform radiological examination with administration of IV contrast and such additional procedures as are considered therapeutic on the basis of the findings during the course of the said procedure.

I hereby certify that I have read and fully understand the above.

Name: _____ Date: _____

Signature: _____Weight:: _____ Employee Initial:_____

ASSIGNMENT OF BENEFITS

Name of Policy Holder _____

Health Insurance Claim Number _____

I request the payment of authorized insurance benefits be made on my behalf to:

NEW YORK MEDICAL IMAGING ASSOCIATES P.C.

for any services furnished by the physician. I authorized any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will be valid for all subsequent visits unless cancelled by the beneficiary.

Patient's Signature _____

Date_____

MEDICARE ASSIGNMENT OF BENEFITS

_____ _____

Name of Patient: Medicare ID Number:

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to:
NEW YORK MEDICAL IMAGING ASSOCIATES P.C. for any services furnished to me.

I authorize any holder of medical information about me to release to the Health Care Finance Administration (HCFA) and my Medigap Health Insurer (if applicable) and its agents any information needed to determine these benefits or the benefits payable for related services.

This assignment shall serve as a lifetime assignment, unless otherwise requested by the above named beneficiary.

_____ _____

Patient's Signature Date