



**Registration Form**

**PATIENT INFORMATION**

Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer Name \_\_\_\_\_ Job Title \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**POLICY HOLDER INFORMATION**

please check if same as above

Name \_\_\_\_\_ Address \_\_\_\_\_

Relationship \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

On the Job Injury? Yes No DOI \_\_\_\_\_ Motor Vehicle Accident? Yes No Date \_\_\_\_\_

**RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION**

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Envision Imaging of North Fort Worth. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider via mail, email, fax, or website. I authorize Envision Imaging of North Fort Worth to release to my insurance company any medical information which may be necessary to process my insurance claims. I understand that in the event my insurance company denies the claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Envision Imaging North Fort Worth's Privacy Notice. Initials \_\_\_\_\_

Print Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

## CT AND IV CONTRAST HISTORY AND SCREENING FORM

Patient Name \_\_\_\_\_ Sex: M F

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Explain your medical problem in detail that is the reason for you having this CAT Scan test today.  
(Where is the problem? How long have you had this problem?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had a previous exam related to this problem?**  Yes  No **If yes, where was the exam performed?** \_\_\_\_\_

List other medical problems: \_\_\_\_\_

List previous surgeries: \_\_\_\_\_

List all allergies: \_\_\_\_\_

### **Are you taking any of the following medications?**

Glucophage, Glucophage XR, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Metformin Tablets, Metformin XR Tablets, Riomet Oral Solution, Insulin, Janumet, Januvia?

**Yes (If yes, circle medication)**  **No**

Have you ever had an allergic reaction to x-ray contrast?  Yes  No

If yes, explain: \_\_\_\_\_

### **Any personal history of:**

Asthma  Yes  No

Diabetes  Yes  No

Kidney Disease  Yes  No

Cancer  Yes  No

Hypertension  Yes  No

Multiple Myeloma  Yes  No

Are you breast-feeding?  Yes  No

Are you pregnant at this time?  Yes  No

Are you on any blood thinners  Yes  No

When was the **first** day of your last menstrual cycle? \_\_\_\_\_

What birth-control method are you currently using? \_\_\_\_\_

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist **that I am not pregnant** at this time.

\_\_\_\_\_  
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
TECHNOLOGIST SIGNATURE

\_\_\_\_\_  
DATE

**ENVISION IMAGING**  
**INFORMED CONSENT FOR CAT SCAN WITH OR WITHOUT  
CONTRAST INJECTION**

**PATIENT NAME:** \_\_\_\_\_

**IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE  
FACILITY PERSONNEL AT ONCE.**

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, are pregnant or breast feeding, you **MUST** inform the technologist.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CAT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

DATE: \_\_\_\_\_

\_\_\_\_\_  
Technologist Signature

DATE: \_\_\_\_\_

Technologist Notes Below

\_\_\_\_\_ CC's    \_\_\_\_\_ No IV Contrast used

Omnipaque or Visipaque

Inj. Site \_\_\_\_\_