



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 _____

Ultrasound History & Screening Form

Date: ____/____/____ Patient: _____ Sex: M F

Age: _____ DOB ____/____/____ Weight: _____ Height: _____

*****Female Patients Only*****

First day of Last Menstrual Cycle: _____

How many times have you been pregnant? _____

How many children have you delivered? _____

Why are you having this test today?

Have you had previous imaging related to this problem? Yes: _____ No: _____

If Yes, where was the exam performed? _____

List any other medical problems: _____

List all previous surgeries: _____

List all allergies: _____

Technologist Notes: _____

I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient/Parent/ Legal Guardian Signature Date: _____

Technologist Signature Date: _____

Envision Imaging NFW
4232 Heritage Trace Parkway
Keller, TX 76248
817-741-0008

Informed Consent for Ultrasound / Sonogram

Patient Name: _____ DOB: _____

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound waves and a computer to produce images of internal body parts.

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

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. 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: _____

Additional Technologist Notes