ENVISION IMAGING

# REGISTRATION INFORMATION

## PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last: _____ First: _____ MI: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____ DOB: _____

Social Security#: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer: _____ Job Title: _____

Employer Address: _____ Work Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone number: _____

## RESPONSIBLE PARTY INFORMATION

Last: _____ First: _____ Relationship to Patient: _____

Address: _____ Social Security #: _____

DOB: _____ Employer: _____

Employer Address: _____ Phone Number _____

## INSURANCE INFORMATION

On the job injury: _____ Motor Vehicle Accident: _____

### Primary Insurance

Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Policy Holder: _____ Policy #: _____ Group Number: _____

Adjuster: _____

### Secondary Insurance

Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Policy Holder: _____ Policy #: _____ Group Number: _____

## 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. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider. I authorize Envision Imaging to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim I will be held financially responsible for all charges. I acknowledge that I have received a copy of Envision Imaging's Privacy Notice.

Initials _____

Signed: _____ Date: _____

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## PET/CT WORKSHEET

Name: _____ Date: _____ Age: _____ Ht: _____Wt: _____ Sex: _____

Did you follow the 24 hr dietary prep? ☐ Yes ☐ No When did you last eat? _____ @_____AM /PM
Did you drink water yesterday & today? ☐ Yes ☐ No
Have you performed any strenuous activity ☐ Yes ☐ No Type/duration: in the last 24 hrs? _____

**MEDICAL/SURGICAL HISTORY** (List all prior surgeries with dates):

_____

_____

Do you have seizures? ☐ Yes ☐ No Explain: _____

Have you had a recent infection? ☐ Yes ☐ No Type/ Location: _____

Have you had a Colonoscopy? ☐ Yes ☐ No Date: _____ Polyps biopsied or removed? Y/N

List locations of any implanted metal: Type/ Location: _____

**PRIOR STUDIES**:

Where/when was your most recent CT done? Date: _____ Type: _____Location: _____

Where/when was your most recent MRI done? Date: _____Type: _____Location: _____

Prior PET/CT Exams? ☐Yes ☐No Where? _____

Did you bring outside CD/Films with you? ☐Yes ☐No

**CANCER HISTORY:**

Have you **had**/ do you **have** a current known cancer, tumor or malignancy? _____

Have you had a recent biopsy? ☐Yes ☐ No Date(s) Area(s): _____

Have you had Radiation Therapy? ☐Yes ☐ No Date(s) Area(s) Completed: _____

Have you had Chemotherapy? ☐Yes ☐ No Date Last Course Completed: _____

Recent Neupogen/Neulasta injections? ☐Yes ☐ No When? _____

When is your follow up appointment? _____ When do you resume treatment? _____
Copy of your report sent to? _____

*****TECHNOLOGIST USE ONLY*****

**CENTER:** S. ARL **NET DOSE : _____mCi @ _____**

**EXAM**: FDG PET/CT Sodium Fluoride F-18 PET/CT Bone **GLUCOSE : _____mg/dL**

**CIRCLE ONE**: New Diagnosis Follow Up Initial Stage Restage

**DIAGNOSIS ON ORDER:** _____ **SEPARATE CT'S PERFORMED:** _____

☐ Skull Base to Mid Thigh (Standard) ☐ Skull Vertex to Mid Thigh ☐ Total Body (2-Part Exam)

**IV SITE:** ☐ RIGHT ☐ LEFT **CIRCLE ONE:** Hand Wrist Antecubital Power PICC/Port

**TECH TECHNOLOGIST:** _____Hard Table ☐ / Soft Table ☐ Arms: Up / Down Scan Direction: P – H or H – P Diabetic: Y/N

Assay_____@ _____ Residual _____ @ _____ Time Per Bed: _____ Min Table Height _____