CHESAPEAKE MEDICAL IMAGING

Patient First Name_____ Patient Last Name _____

Birth Date: _____ Age:_____ Gender:_____

Patient Address: _____ City: _____

State: _____ Zip_____ Home Phone: _____ Mobile Phone: _____

Email: _____

Primary Care Physician: _____

Emergency contact:

Name: _____ Relation: _____ Phone: _____

Insurance Information:

Primary Insurance Company:_____

Policy Number: _____ Group Number: _____

Is this related to an injury: ☐ Yes ☐ No

If yes, please indicate one of the following : ☐ Auto ☐ Work ☐ Personal

Patient Authorization:

1) I hereby authorize Chesapeake Medical Imaging to apply for healthcare benefits on my behalf for the services rendered. I request that payments from any government sponsored healthcare program, insurance company or independent carrier with which CMI contractually participates be made directly to CMI. I certify that the above insurance information is correct.
2) I authorize the release of any medical records inclusive of test results and pertinent information acquired during my treatment, to/from other physicians and Healthcare providers.
3) I understand that I have the right to receive upon request, a copy of CMI'S notice of privacy practices which describes how CMI will use and disclose my information. I understand that CMI does not need my permission to disclose health information for purposes related to treatment, payment or routine business operations.
4) In addition, by signing below I authorize the release and disclosure of my medical information to the following individuals. I understand that this authorization extends to all of my protected health information that is disclosed for general information purposes and is valid until it is revoked.

_____ _____ / _____ _____

Name Relation Name Relation

Signature:

I agree that the above is true to the best of my knowledge.

_____Date_____

Patient/ Parent / Legal Guardian Signature

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Patient Name:_____ Birth Date: _____/_____/_____

Race:

☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiin or Pacific Islander ☐ White ☐ Decline to State

Smoking History:

☐ Current smoker: _____packs per day ☐ Occasional ☐ Former: _____ Yr quit ☐ Never Smoker

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic ☐ Decline to State

Primary Language:

☐ English ☐ Spanish

Please answer the following questions:

Pregnant or chance of pregnancy: ☐ YES ☐ NO Last Menstrual Period:_____ Breastfeeding: ☐ YES ☐ NO

Diabetic: ☐ Yes ☐ No Kidney Failure: ☐ Yes ☐ No

Biopsy: ☐ Yes ☐ No Part of body in which biopsy was performed :_____

Pneumonia: ☐ Yes ☐ No Year:_____

Personal History of Cancer: ☐ Yes ☐ No If Yes: Type and Location:_____

Chemotherapy: ☐ Yes ☐ No Dates of Treatment:_____

Radiation Therapy: ☐ Yes ☐ No Dates of Treatment:_____

Contrast Reaction to MRI /CT / X RAY contrast? ☐ Yes ☐ No

Type of Reaction: ☐ Mild (Rash/Hives) ☐ Severe (Trouble Breathing/Blood pressure)

Allergies: ☐ Yes ☐ No Please explain:_____

Briefly Describe the reason for your visit. Include symptoms, location, side, day of onset, duration:

Current Medications: (You may also provide us a copy of your list or use the back of this form)

_____ _____

Patient Signature Date

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