Radiology Center of Fair Lawn
Patient Information Form – CT Scan

Patient Chart #: _____ Date: _____

[ ] Male[ ] Female

Patient Name: _____ Date of Birth: ___/___/____ SS#: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #'s: (Home) _____ (Work) _____ (Cell) _____

Referring Physician: _____ Phone #: _____ /Fax#: _____
Additional Physician: _____ Phone #: _____ /Fax#: _____

Primary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the primary insurance carrier? YES NO
If **NO**, please fill out the following information:
Name of Primary Insurance carrier: _____ Relationship to Patient: _____
Date of Birth: ___/___/____ Primary Insurers SS#: _____ Phone #: _____

Secondary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the secondary insurance carrier? YES NO
If **NO**, please fill out the following information:
Name of Secondary Insurance carrier: _____ Relationship to Patient: _____
Secondary Insurers Date of Birth: ___/___/____ Secondary Insurers SS#: _____ Phone #: _____

In the event of an emergency, please contact:
Name: _____ Relationship: _____ Phone #: _____

Why is your referring physician requesting that you have this exam? _____
Is there any possibility of pregnancy? YES NO
Are you currently breast feeding? YES NO
Have you had any previous surgery to the location in which we will be scanning? YES NO
If YES, please list the type of surgery and the procedure date: _____
Have you ever been diagnosed with cancer? YES NO
If YES, please list the type and form of treatment: _____
Have you had any relevant x-rays or other testing done prior to today's exam? YES NO
If YES, when and where were the prior tests performed and what were the results? _____

[For CT Scans with IV Contrast Only]
Do you have any allergies to any foods, drugs, or vespids? YES NO
If YES, please list and explain to what and the reaction: _____
Do you have asthma? YES NO
Do you have any kidney disease or dysfunction? YES NO
Do you have diabetes? YES NO
If YES, please list the type of diabetes medications you are currently taking: _____
Which doctor manages your diabetes? _____ Phone: _____
Have you been pre-medicated for this exam? YES NO
Have you ever had IV Contrast before in the past? YES NO
If YES, how many times have you had IV Contrast? _____
Did you have any reaction to the IV Contrast? YES NO
If YES, what type of reaction did you have? _____

I attest that the above information is correct and true to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding its requested information.

Signature (Patient or Legal Guardian): _____ Date: _____