

PATIENT REGISTRATION

Name _____ Social Security # _____ - _____ - _____

<i>Last</i>	<i>First</i>	<i>Middle</i>	
Address	Birth Date:	Cell phone ()	Age

City	St	Zip	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Injury
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Phone () - _____ Referred by: _____

 Accident? Yes No / Auto Work Other Employment Status: Employed Student (F/T-P/T)

Employer	Occupation	Work Phone () -
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Nearest Relative/Friend Not Living with You	Phone () -
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Spouse Name	Spouse Employed by:	Phone () -
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Insurance Information

Medical Ins. Co. #1

Social Sec. # Of Insured	Policy# or Group#	Relationship to patient
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Insured's Name	Authorization:
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DOB of Insured	Employer	Insurance Name
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Address	City	St	Zip	Phone () -
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Medical Ins. Co. #2

Social Sec. # Of Insured	Policy# or Group#	Relationship to patient
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Insured's Name	Authorization:
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DOB of Insured	Employer	Insurance Name
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Address	City	St	Zip	Phone () -
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 Attorney? Yes No Attorney Name: _____ Phone () - _____

Auto/Work Comp Ins. (Name/Address) _____

Adjuster Name	Phone () -
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I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING MEDICAL GROUP, INC** I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature _____ Date _____

CT CORONARY ARTERY CALCIUM SCORING
PATIENT CLINICAL HISTORY
PLEASE PRINT CLEARLY

NAME: _____ AGE: _____ SEX: _____
Last First Middle

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone #: _____

Have you been a patient in a hospital in the past 5 years? YES NO Reason: _____

Have you had any serious illnesses or operations? YES NO

Briefly list operations: _____

*FOR WOMEN ONLY: Are you or do you think you could be pregnant? YES NO

If you think you may be pregnant, please notify the technologist before your exam!

#	Description	Yes	No	#	Description	Yes	No	#	Description	Yes	No
1	Heart Disease			10	Arthritis			18	Allergies to:		
2	High Cholesterol or High Lipids			11	Tumor History				Penicillin		
3	Family History of Heart Disease			12	Radiation Treatment				Other Antibiotics		
4	High Blood Pressure			13	Liver or Kidney Disease				Codeine, Aspirin		
5	Rheumatic Fever			14	Hepatitis (A, B, C), Jaundice				Local Anesthetic		
6	Thyroid disease			15	AIDS / HIV +				Other		
7	Diabetes			16	Asthma, Emphysema, Bronchitis			19	Do you smoke?		
8	Stroke			17	Tuberculosis			20	Have you ever smoked?		
9	Heart Attack							21	How many years?		

Please list any disease, condition, or problem not listed above:

List any medication, drugs, pills (prescription or non-prescription) you are currently taking:

REMARKS:

