

## PATIENT REGISTRATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Last* \_\_\_\_\_ *First* \_\_\_\_\_ *Middle* \_\_\_\_\_  
 Address \_\_\_\_\_ Birth Date: \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Sex: M  F  Date of Injury \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Referred by: \_\_\_\_\_

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Nearest Relative/Friend Not Living with You \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Employed by: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

### Insurance Information

#### Medical Ins. Co. #1

Social Sec. # \_\_\_\_\_  
 Of Insured \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy# or Group# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Name \_\_\_\_\_ Authorization: \_\_\_\_\_

DOB of Insured \_\_\_\_\_ Employer \_\_\_\_\_ Insurance Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

#### Medical Ins. Co. #2

Social Sec. # \_\_\_\_\_  
 Of Insured \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy# or Group# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Name \_\_\_\_\_ Authorization: \_\_\_\_\_

DOB of Insured \_\_\_\_\_ Employer \_\_\_\_\_ Insurance Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Attorney? Yes  No  Attorney Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Auto/Work Comp Ins. (Name/Address) \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

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 \_\_\_\_\_

**ULTRASOUND 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

List Operations: \_\_\_\_\_

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

Date last menstrual period began: \_\_\_\_\_

**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:

\_\_\_\_\_  
 \_\_\_\_\_