X-Ray, Injection and Ultrasound

Last Name:____________________

First Name:____________________

DOB:__________ Date:__________

Height:__________ Weight:__________lbs/kgs

Any previous exams related to todays problem? Yes / No

Exam:__________Location:__________Date:__________

List previous surgeries:__________

List current Medications:__________

Any medication, food or latex allergies:__________

Any Personal History of :

Yes	No	
☐	☐	Headaches
☐	☐	Liver Disease
☐	☐	Diabetes
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Allergic Respiratory Disease
☐	☐	Dizziness
☐	☐	Kidney Disease/Kindey Failure
☐	☐	Are You on Dialysis?
☐	☐	Bladder Disease
☐	☐	Cancer
☐	☐	Heart Disease
☐	☐	Seizure Disorder
☐	☐	Multiple Myeloma
☐	☐	Blood disorder/Sickle Cell
☐	☐	Recent diarrhea in past 2-3 days?
☐	☐	History of falls in the last 30 days

Females Only:

Are you pregnant:__________

Are you breast feeding:__________

Last menstrual period:__________

Any other medical problems, infections or concerns:

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I understand the risk of having an x-ray while pregnant and I do not believe I am pregnant.

I authorize Alliance Healthcare Services, Inc., its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Alliance and I authorize payment to be made directly to Alliance. In Medicare assigned cases, Alliance agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-Pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Alliance's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities.

I have read and I understand, acknowledge and agree to the content of this General Concent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature:__________ Date:__________ Time__________

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship:__________

Technologist Signature:__________