CT Patient History Sheet

āylo health

Patient Name: _____ Date: _____

Date of Birth: _____ Best Contact Number: _____

Age: _____ Height: _____ Weight: _____

Reason for exam (present complaint requiring CT Scan): _____

Date of your last menstral period: _____

Past or Present history of Cancer? ☐ Yes ☐ No If yes, what type? _____

List any past surgeries done in the area being scanned today (i.e. appendectomy/hysterectomy):

_____

_____

Are you currently experiencing Pain? ☐ Yes ☐ No If yes, list the location _____

Do you take Metformin containing drugs (these are medications for diabetes or PCOS, e.g., Glucophage or Glucovance)? If you are unsure, speak with the technologist. ☐ **Yes** ☐ **No**

Do you have or have you ever had a history of:

High Blood Pressure	☐ Yes	☐ No	Sickle Cell Anemia	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Multiple Myeloma	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Scleroderma/Lupus	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	If yes, what Medication do you take: _____		
Medication Allergy	☐ Yes	☐ No	If yes, please list: _____		
Heart/Vascular Disease	☐ Yes	☐ No	If yes, please list: _____		
Chemotherapy	☐ Yes	☐ No	If yes, date of last treatment: _____		

Any previous CT studies? ☐ Yes ☐ No

If yes, where and when? _____

Previous reaction to contrast (X-ray Dye, Iodine, IVP or Angiography)? ☐ Yes ☐ No

If yes, describe reaction and treatment: _____

_____

_____ _____

PATIENT SIGNATURE DATE

***By signing this form, I hereby attest that all information on this form is true and correct.**

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Office use only

Additional Information for Radiologist:

Type of CT Scan: Dose: CTDI: DLP:

Contrast: Volume: MLPS: Lot #: Expiration:

Patient Account Number: Name of Odering Provider:

CT Technologist Signature:

Insurance Waiver

Date of Service: Patient Name:

Account #: Provider Name:

Exam/Procedure/Service:

I elect to receive services today for the services listed above and agree to pay any and all of the balance due related to this procedure if not covered by insurance. Possible denial reasons are listed below:

- These services may be non-covered by my insurance for any reason
- These services may not be eligible for payment under my specific benefits and plan
- This provider may not be recognized under my insurance plan for payment

I have read and understand that by signing this waiver, I am consenting to receive the above mentioned services and understand that I may incur a balance due to these services not being covered by my insurance policy. I elect to receive the services anyway and agree to pay any balance due.

SIGNATURE OF PATIENT OR GUARDIAN DATE

If we cannot verify your insurance, you will be considered Self Pay