CT Patient History Sheet Date: _____

Patient Name: _____ D.O.B. _____/_____/_____ Age:_____

Best Contact Number: _____-_____-_____ Height _____ Weight _____

Reason for Exam (present complaint requiring CT Scan): _____
Date of your last menstrual 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 location of pain: _____

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.**

Office Use only:

Additional Information for Radiologist: _____

_____

Type of CT Scan: _____ *Dose: CTDI:* _____ *DLP:* _____

Contrast: _____ *Volume:* _____ *MLPS:* _____ *Lot #:* _____ *Expiration:* _____

Patient Account Number: _____ *Name of Ordering 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.

_____ Date:_____

Signature of Patient or Guardian

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