

# ZILKHA RADIOLOGY

Long Island Magnetic Resonance Imaging, P.C.

Long Island Medical Imaging, P.C.

Long Island Medical Diagnostic Imaging, P.C.

369 EAST MAIN STREET; SUITE 18  
EAST ISLIP, NY 11730  
(631) 277-1600 /FAX (631) 277-1638

1161 MONTAUK HIGHWAY  
WEST ISLIP, NY 11795  
(631) 669-1717 /FAX (631) 669-2227

Today's Date \_\_\_\_\_ Time of Appointment \_\_\_\_\_ Time of Arrival \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ **Male Female**

Street \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Telephone # \_\_\_\_\_ Mobile # \_\_\_\_\_

Employer \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder (If not yourself) \_\_\_\_\_ Relationship **Spouse Parent Dependent Other**

Policy Holder's: Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship **Spouse Parent Dependent Other**

Referring Doctor Name & Phone # \_\_\_\_\_

Other Doctor's you want your results sent to: \_\_\_\_\_

(Name, Town & Phone Number)

Is this condition Employment Related? **YES NO** Automobile Accident? **YES NO**

[If YES – you MUST complete No-Fault/Workers Compensation forms in addition to this form]

Pre-existing condition? **YES NO** Signature \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT:** I hereby consent to treatment by the radiologist and other medical staff for all tests and/or procedures by Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C.

**Patient or Legal Guardian Initial** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby assign Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. to release any information acquired in the course of my examination and treatment to my insurance company.

**Patient or Legal Guardian Initial** \_\_\_\_\_

**AUTHORIZATION OF PAYMENT:** I hereby assign payment to Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. for the medical benefits due under the terms of my insurance policy. I fully understand that I am financially responsible for my deductible, co-payment, co-insurance, and charges not covered by my health insurance plan.

**Patient or Legal Guardian Initial** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES (HIPAA) & RELEASE OF MEDICAL RECORDS:** I acknowledge that I have been provided with a copy of Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. (the Practice's) Notice of Privacy Practices. I authorize release of my films/images, reports and/or medical records to my referring doctor, and any other doctor listed above. I authorize the persons listed below to discuss or retrieve any information pertaining to my treatment. (Photo ID required)

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

I hereby authorize a photo copy of this form to be valid as the original. This authorization will remain in effect unless changed by myself. I have read and understand the above, and agree to the terms listed above.

**Patient or Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FEMALES (Except Ultrasound):**

Yes, I am pregnant       No, I am not pregnant       Yes, I am nursing       No, I am not nursing

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**MRI & MRA PATIENTS:**

**YES NO** Do you have a Cardiac Pacemaker, Mechanical Heart Valve or Defibrillator?  
**YES NO** Have you had head surgery (Brain, Eye, Ear)? Explain \_\_\_\_\_  
**YES NO** Do you have Intracranial or Aneurysm Clips?  
**YES NO** Have you had Vascular, Cardiac, Abdominal or Back Surgery? Explain \_\_\_\_\_  
**YES NO** Is there a possibility of a metal object in your eye from work or an accident?  
**YES NO** Do you have a Hearing Aid, Dentures, Bridges, Braces, Retainer?  
**YES NO** Are there any Metal or Electrical Devices, implanted or external, such as an insulin pump, shrapnel, prosthesis, metal sutures, and/or neurostimulator anywhere in the body?

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**CT SCAN PATIENTS:**

**YES NO** Have you had an IV contrast allergy? If YES, what was your reaction? \_\_\_\_\_  
**YES NO** Do you have asthma?  
**YES NO** Do you have any allergies? List \_\_\_\_\_  
**YES NO** Do you have a history of renal failure?  
**YES NO** Are you a Diabetic? List Treatment \_\_\_\_\_  
**YES NO** Do you have sickle cell anemia?  
**YES NO** Do you have multiple myeloma?  
**YES NO** Do you have an allergy to latex?

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**ALL PATIENT'S PLEASE COMPLETE:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ History of Seizures? **YES NO** Explain \_\_\_\_\_

Why does your doctor want you to have this test? \_\_\_\_\_

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Have you ever had the test before? **YES NO** Where & When? \_\_\_\_\_

Are you currently a smoker? **YES NO** Packs per day? \_\_\_\_\_ Ex-smoker, When did you quit? \_\_\_\_\_

Do you have any current medical conditions? **YES NO** Explain \_\_\_\_\_

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Are you a diabetic? **YES NO** List Medications \_\_\_\_\_

Are you currently taking any medications? **YES NO** List \_\_\_\_\_

Have you had recent abnormal blood work? **YES NO** Results? \_\_\_\_\_

Have you had any surgery? **YES NO** Explain \_\_\_\_\_

Do you have a personal history of cancer? **YES NO** What type? \_\_\_\_\_

Do you have cancer that is in remission? **YES NO** What type? \_\_\_\_\_

What treatment did you receive? \_\_\_\_\_ How long have you been in remission? \_\_\_\_\_

Are you experiencing any pain? **YES NO** Explain \_\_\_\_\_

Do you have any heart disease? **YES NO** Explain \_\_\_\_\_

Are there any other medical conditions/symptoms we should be aware of? \_\_\_\_\_

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I hereby state that the information listed above is accurate to the best of my knowledge.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date