# Pueblo Radiology / Santa Barbara Women's Imaging Center
# Patient Information Sheet

**Day / Time of Appt:** [Examday] - [ExamTime] - [Modality] **MRN: [MRN]**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Patient**: | [LastName] | [FirstName] | [M] | [DOB] | [Age] | [sex] |
| | *Last Name* | *First Name* | *M.I.* | *DOB* | *Age* | *Gender* |
| **Address**: | [Address] | [City] | | | [State] | [Zip] |
| | *Street / P.O. Box* | *City* | | | *State* | *Zip Code* |
| **Phone**: | [HomePhone] | [CellPhone] | **Preferred:** ☐ Home ☐ Cell ☐ Other: _____ | | | |
| | *Home* | *Cell* | | | | |
| **Email**: | [email] | | **Height:** [height] | | **Weight:** [wt] | |

**Referring Physician:** [refdoc] **Office:** [office] **Fax:** [fax]

**Other physicians you would like to receive a report of today's examination(s):**

_____

What are your current symptoms / reason for exam? _____

Is your examination today related to an injury at work? ☐ No ☐ Yes

Do you have, or have you had, cancer? ☐ No ☐ Yes, type and when?
_____

Have you had prior exams of area being imaged today? ☐ No ☐ Here ☐ Yes, where? _____-
_____

Please list the type and date of any other surgeries related to today's imaging study:

_____

Female Patients: Are you pregnant? ☐ No ☐ Yes ☐ Unsure (Initials: _____*MD consulted: _____)
Are you breast feeding? ☐ No ☐ Yes

Medicare Patients:
Are you **temporarily** residing at a skilled nursing facility? ☐ No ☐ Yes, where? _____

**Notice of Privacy Practices and Use of Contact Information**
I have received a copy of the Notice of Privacy Practices from Pueblo Radiology (PR) / Santa Barbara Women's Imaging Center (SBWIC) concerning how the use and disclosure of Protected Health Information is handled by this practice. I also acknowledge and consent that PR / SBWIC may use any phone number or email I provide to remind me of appointments and communicate with me concerning services provided and billing matters.
**Initial: _____**

I have reviewed the information above and confirm that it is accurate.

_____ **Date: [Examday]**
***Patient signature (or legal guardian)***

Office use:

☐ MR ☐ CT ☐ Mam ☐ US ☐ Vas ☐ Dexa ☐ XR-Fl Creatinine:_____ *(if applicable)*

Registered by: _____ Time: _____
Order: ☐ Here ☐ Patient to Bring ☐ Correct MD ☐ cc MDs added ☐ Auth Verified
Exam: ☐ Left ☐ Right Exam Type : _____ ☐ Patient Name ☐ Middle Initial