HIGH FIELD 1.5 T MRI
OPEN MRI
CARDIAC NUCLEAR MEDICINE
16-SLICE CT ANGIOGRAPHY
DIGITAL GENERAL RADIOGRAPHY
DIGITAL MAMMOGRAPHY

KAMALESH A. AMIN, M.D.
AMER CAN BOARD OF RADIOLOGY CERTIFIED

CDC
CITRUS DIAGNOSTIC CENTER
& PET/CT Scan

16- SLICE PET/CT SCAN
COMPUTED TOMOGRAPHY
ULTRASOUND
VASCULAR DOPPLER STUDIES
ECHOCARDIOGRAPHY
OSTEOPOROSIS DEXA SCAN

NAME: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESSS: _____

MAILING ADDRESS: _____ APT OR LOT# _____

CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ GENDER: M F

RACE: _____ ETHNICITY: (CIRCLE) HISPANIC/LATINO/NOT HISPANIC OR LATINO/DECLINE

PREFERRED LANGUAGE IF OTHER THAN ENGLISH: _____ KNOWN DRUG ALLERGIES: _____

HISTORY OF SMOKING? Y N IF YES, HOW LONG: _____ AMOUNT PER DAY? _____ YEAR QUIT: _____

NAME OF INSURANCE COMPANY: _____

EMPLOYER NAME: _____ EMPLOYER PHONE #: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

IN CASE OF MINOR/ NAME: _____ RELATIONSHIP: _____

PHONE: _____ SOCIAL SECURITY # _____

ADDRESS: _____

I HEREBY AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL RECORDS & X-RAYS TO CITRUS DIAGNOSTIC CENTER:

_____

FINANCIAL INFORMATION

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCES NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND IT IS MY RESPONSIBILITY TO VERIFY MY INSURANCE COVERAGE FOR ANY EXAMS PERFORMED AT CITRUS DIAGNOSTIC CENTER. NOT ALL INSURANCE COMPANIES MAY PAY 100% OF THE CHARGES. IF IT BECOMES NECESSARY TO COLLECT ANY SUM DUE THROUGH AN ATTORNEY, THEN THE PATIENT AND/OR GUARANTORS AGREE TO PAY ALL REASONABLE COSTS OF COLLECTIONS, INCLUDING ATTORNEYS FEES AND APPELLATE ATTORNEYS FEES, WHETHER SUIT IS FILED OR NOT. ALL PAST DUE BALANCES WILL ACCRUE INTERST AT A RATE OF 15% PER ANNUM. I UNDERSTAND THAT THE FILMS AND OTHER ORIGINAL RECORDS ARE THE PROPERTY OF CITRUS DIAGNOSTIC CENTER. I AUTHORIZE RELEASE OF ANY RECORDS NECESSARY TO FILE INSURANCE CLAIMS AND TO ANY TREATING PHYSICIANS.

PATIENT, PARENT, OR GUARANTOR: _____ DATE: _____