PATIENT NAME:

ACCCOUNT:

ADDRESS:

PRIMARY INSURANCE:

***Fill out during pre-registration by NSI staff**

*PRIOR SURGERIES with approximate dates (including biopsies or pain injections):

*CANCER OR H/O CA: ☐ YES ☐ NO IF YES TYPE OF CANCER

PLEASE CHECK INFORMATION ABOVE LINE FOR ACCURACY

To assist the Radiologist interpreting your exam today please answer the questions below as accurately as possible.

What is your chief complaint regarding the body part being imaged today?

Did you sustain an injury to the area being scanned? (Example, a fall or other accident) if so briefly describe the injury and the date.

Have you received any other treatment for the problem (medication, chemotherapy, radiation therapy etc…?)

Describe the specific location of your pain, numbness or other symptoms.

Do you have any other Medical Conditions – if yes please list.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

SIGNATURE (parent or guardian if under 17 and under)

_____ Date Signed_____