



6920 McGinnis Ferry Road  
Suite 300  
Suwanee, GA 30024  
678-835-2299

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Sex: Male or Female    Marital Status: Married    Single    Divorced    Widowed

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Customer Service Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Johns Creek Diagnostic Center**  
2690 McGinnis Ferry Road, Suite 300  
Suwanee, Georgia 30024

# CT

## PATIENT HISTORY & QUESTIONNAIRE

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Today's Date \_\_\_\_\_

Any known allergies? \_\_\_\_\_

If yes, please list all \_\_\_\_\_

Have you ever had a CT/IVP Contrast Study? \_\_\_\_\_

If yes, what kind? \_\_\_\_\_

Did you have a reaction? If yes, please describe \_\_\_\_\_

**Any prior surgery?** \_\_\_\_\_

If yes, please list all \_\_\_\_\_

Current Medications: \_\_\_\_\_

### Medical History

High Blood Pressure	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	COPD	Yes	No
Pheochromocytoma	Yes	No	Diabetic	Yes	No
Myasthenia Gravis	Yes	No	Kidney Disease	Yes	No
Multiple Myeloma	Yes	No	Dialysis	Yes	No
Sickle Cell Anemia	Yes	No	Cancer	Yes	No

**Please list all symptoms relating to your exam:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Exam: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

MR Number: \_\_\_\_\_ Accession: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Technologist Signature: \_\_\_\_\_

Contrast Type \_\_\_\_\_

Amount \_\_\_\_\_

Lot # \_\_\_\_\_

Expiration Date \_\_\_\_\_

IV ACCESS

Catheter Size \_\_\_\_ Time \_\_\_\_

Site \_\_\_\_\_

THERE IS NO CHARGE WHEN ORIGINAL RECORDS ARE SENT TO A PHYSICIAN FOR CONTINUING CARE. A COPYING FEE OF \$10 PER SHEET IS CHARGED THEREAFTER WHEN RECORDS ARE RELEASED TO A PATIENT, OTHER PHYSICIAN, OR THE ORIGINAL ARE LOST BY THE ORIGINAL RECEIPIENT.

**Authorization to Receive or Release Medical Information**  
**(Please fill out completely; incomplete forms may delay processing)**

**1. Explanation**

This authorization to receive or release medical information is being requested of you to comply with the terms of the "Confidentiality of Medical Information Act of 1981, Section 56, et. Seq., of the California Civil Code."

**2. Authorization**

I hereby authorize Johns Creek Diagnostic Center to furnish to :

\_\_\_\_\_  
(Name of physician, hospital or healthcare provider) \_\_\_\_\_ (Type of Exam)

Medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

\_\_\_\_\_  
(Name of Patient) \_\_\_\_\_ (Social Security Number) \_\_\_\_\_ (Date of Birth)

**3. I understand that I have the right to limit the type of information to be released. I have indicated below the information that is authorized for release:**

All medical information, without exception, including information regarding AIDS and AIDS testing, psychological or psychiatric treatment and drug or alcohol abuse. This includes doctor's notes, labs, x-ray and other diagnostic tests.

All the medical information except the following: \_\_\_\_\_

Only the following information: \_\_\_\_\_

**4. Uses**

This information supplied is to be used for the following purpose (s): continuity of medical treatment

**5. Duration**

This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (date).

**6. Restrictions**

I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**7. Additional Copy**

I understand that I have a right to receive a copy of this authorization.

Copy requested and provided:  yes  no

**8. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above and reserve the right to charge for copies of medical records.**

Signed:

\_\_\_\_\_  
(signature) \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Print Name) \_\_\_\_\_ Witness: \_\_\_\_\_

\*If signed by other than patient, indicate relationship: \_\_\_\_\_

\*Authorized representative must submit copies of legal document supporting assignment of this authority.