WASHINGTON HEIGHTS IMAGING
VIDA WOMEN'S HEALTH CENTER

4334 Broadway
New York, NY 10033
(212) 927-1717 Fax (212) 927-5080

Last Name (**Apellido**): _____ First Name (**Nombre**): _____ MI: _____

DOB (**Fecha de Nacimiento**) ____/____/____ SSN (**Seguro Social**): _____

Sex (**Sexo**): □ Female(Mujer) □ Male(Hombre) Marital Status (**Estado Marital**):_____

Adress (**Direccion**): _____ Apt #: _____

City (**Ciudad**):_____ State (**Estado**):_____ Zip Code(**Codigo**): _____

Phone# (**Telefono**): ___-___-___ Cell# (**Celular**): ___-___-___ Work# (**Trabajo**): ___-___-___

Emergency Contact (**Contacto de Emergencia**): _____

Emergency Contact Relationship (**Relacion del Contacto**) _____ Emergency # (**# de Emergencia**) ___-___-___

ARE YOU PREGNANT (PUEDE ESTAR EMBARAZADA)? □**Yes (Si)** □**No (No)**

INSURANCE INFORMATION (INFORMACION DEL SEGURO)

Primary Insurance (**Seguro Primario**): _____ Insured's SSN _____

Insured ID (**ID del Asegurado**): _____ Policy/Carrier #: _____ Group# (**No. Grupo**): _____

Primary Insurance Co. Address (**Direccion del Seguro**): _____

City (**Ciudad**):_____ State (**Estado**):_____ Zip Code(**Codigo**): _____

Relationship with Insured (**Relacion con Asegurado**) □ Self □ Spouse □ Child □Dependent

Insured's Full Name (**Nombre del Asegurado**) _____ DOB (**FDN**) ___/___/___

Secondary Insurance (**Seguro Medico Secundario**) _____ ID#_____

Relationship with Insured (**Relacion con Asegurado**) □ Self □ Spouse □ Child □Dependent

Insurance Co. Address (**Direccion del Seguro**): _____

City (**Ciudad**):_____ State (**Estado**):_____ Zip Code(**Codigo**): _____

Primary Care Physician (**Doctor Primario**) _____

PCP Address (**Direccion**) _____Phone (**Telefono**) ___-___-___

WASHINGTON HEIGHTS IMAGING
CT PATIENT QUESTIONNAIRE

Patient's Name: _____ Age: _____ Date: _____

Are you **PREGNANT?** **Y** **N**

Do you have any known MEDICAL CONDITIONS:

KIDNEY DISEASE	**Y**	**N**	
HIGH BLOOD PRESSURE	**Y**	**N**	
ASTHMA	**Y**	**N**	
SICKLE CELL ANEMIA	**Y**	**N**	
HEART (CARDIAC) DISEASE	**Y**	**N**	
BLOOD DISORDERS	**Y**	**N**	
MYELOMA	**Y**	**N**	
PACEMAKER	Y	N	
CANCER	**Y**	**N**	If yes what type:_____

DIABETES **Y** **N**

Do you take **GLUCOPHAGE** or any other type of **METFORMIN** medication to regulate diabetes? **Y** **N**

If **YES,** have you taken it today? **Y** **N**

Have you had any previous **I.V. CONTRAST** STUDIES? **Y** **N** Reaction? **Y** **N**

PREVIOUS **SURGERY?** _____

_____

Patient's Signature: _____ Date: _____

********** **Technologist Section** **********

Requested Examination: _____

Prior Examination: _____

Reason for Exam: _____

_____

_____

☐ Patient identification and examination verification Technologist Initials_____

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Washington Heights Imaging
43-34 Broadway
New York, NY 11375

Patient Name _____ Date of Birth _____

1. What is your race? ☐ White/Caucasian ☐ Black/African American ☐ Asian
   ☐ Hispanic or Latino/a ☐ Hawaiian/Pacific Islander ☐ Other _____
2. What is your gender? ☐ Male ☐ Female
3. What is your preferred language? _____
4. Do you smoke cigarettes? ☐ Current smoker ☐ Former smoker ☐ Never smoker
5. Are you currently taking any medications? ☐ No ☐ Yes - Please list them with dosage

Prescription Medication	**Dosage**	**Reason For Taking Medication**
Non-Prescription Medication ***(over the counter medication)***	**Dosage**	**Reason For Taking Medication**

6. Do you have any food allergies? ☐ No ☐ Yes Do you have any drug allergies? ☐ No ☐ Yes
   If yes, please list:_____
   _____
7. Email address _____
   (This will allow you to electronically access your records through our Patient Portal. *Long Island Radiology Associates, P.C. respects your privacy and will not use or sell your email address.*)
   ☐ I would like Long Island Radiology Associates, P.C., to send updates, information, and notifications about the practice to the email address above.

Signature_____ Date _____

The American Recovery and Reinvestment Act of 2009 contains the Health Information Technology for Economic and Clinical Health Act (HITECH). This new regulation requires Long Island Radiology Associates, P.C. to document your health history and communication preferences in an electronic format. These questions must be asked each time you visit our facilities, regardless of your exam or diagnosis. Thank you for your cooperation.

All information will be kept confidential as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if the organization authorized to receive the information below is not a health plan or health care provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ ID Number: _____

Organization Providing Information: **Long Island Radiology Associates, P.C.**
Organizations Receiving Information: **Medical Data Base**

Your protected health information may be used and disclosed by your physician, referring physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills. Any other identifiable health information may be disclosed as required by law.

USE OF PURPOSE OF DISCLOSURE:
The purpose of the use of disclosure: Report typing and Billing for Health Care Services.

The description of information: All patient identifiable health information, for billing purposes such as, but not limited to: authorizations, letter of necessity, all information that needs transcribing, as well as any documents useful to ensuing the accuracy of those transcriptions. All relevant information required to file health care claim.

I understand that my healthcare and the payment for my healthcare will not be affected by signing this form.

By my signature below I acknowledge that I have received a paper copy of Long Island Radiology Associates, P.C. notices of privacy practices.

We may use or disclose your protected health information in the following situations without your authorization or opportunity to object.

Patient Health: for public health purposes to a public health authority or to a person who is a risk of contracting or spreading your disease.

Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect or domestic violence.

Food and Drug Administration: As required by the Food and Drug Administration to track products.

Legal Proceedings: In the course of legal proceedings.

Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors and Organ Donors: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.

Soldier's, Inmates, and National Security: to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

Worker's Compensation: to comply with worker's compensation laws or
No-Fault Laws: for disclosure to billing companies- all relevant information required for health care claims.

In general, we may use or disclose your protected health information as required by the law and limited to the relevant requirements of the law.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

_____ _____
Print Name Patient Signature

_____ _____
Patient Representative Date