



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/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: _____ Date of Birth: __/__/____

Policy Holder SSN: ___/___/___ Relationship to holder: _____

ID Number: _____ Group Number: _____

Johns Creek Diagnostic Center
6920 McGinnis Ferry Road, Suite 300
Suwanee, Georgia 30024

X-RAY

PATIENT HISTORY & QUESTIONNAIRE

Name _____ Date of Birth _____
Referring Physician _____ Sex _____ Age _____

List all prior surgeries? _____

Medical History

High Blood Pressure	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	COPD	Yes	No
History of Positive PPD	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 tell us why we are doing this x-ray: _____

Patient Signature: _____ Date: _____

MR #: _____ Accession#: _____

Exam: _____

Technologist Signature: _____

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:

_____ Date: _____
(signature)

_____ Witness: _____
(Print Name)

*If signed by other than patient, indicate relationship: _____

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