



**(602) 485-7482**

Dear Pinnacle Radiology Patient,

This is your registration form for your appointment at ***Pinnacle Radiology-DEER VALLEY*** 19636 North 27th Ave, LL1 (Basement) Phoenix, AZ 85027. Please follow the appropriate preparation for your examination.

This patient registration form and appropriate history forms can be printed, completed and given to us at your appointment. Bringing completed forms will reduce waiting time at your appointment.

If you have visited a Pinnacle Radiology facility in the past 6 months and your information or insurance has not changed, it is not necessary to complete the patient registration form. Please bring your insurance card and any applicable co-pays with you at the time of your appointment. Also, remember to bring your doctors orders if they provided the order to you.

If you have prior studies of the same anatomic area that your appointment is scheduled for, it is very important to arrange for those studies to be available to us for comparison. This includes any CT's, X-rays, or MRI's, even if the test you are currently scheduled for is of a different modality. The best method is to hand carry them if possible, but you can call the facility where the films were done and ask for them to be mailed to the address listed above. Only you can request the release of films due to federal regulations. If you are unsure of the facility, your healthcare provider at that time should be able to tell you where you had prior examinations performed.

**If you are unable to keep this appointment, 24 hour notice would be greatly appreciated.**

Please call **(602) 485-7482** if you need further instructions.

Sincerely,

The Staff of Pinnacle Radiology

**Pinnacle Radiology**

Patient Registration Form

**PLEASE PRINT CLEARLY**

Patient Information

Last Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
First Name \_\_\_\_\_ M. Initial \_\_\_\_\_ Gender M F Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Telephone # \_\_\_\_\_

**Responsible Party (Guarantor if not patient)**

Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Last Name \_\_\_\_\_ DOB \_\_\_\_\_  
First Name \_\_\_\_\_ Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Insured ID# \_\_\_\_\_  
Address \_\_\_\_\_ Group \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Owner \_\_\_\_\_ Birth Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Patient Relation to Policy Owner \_\_\_\_\_ Eff date \_\_\_\_\_ Exp \_\_\_\_\_  
Second Insurance \_\_\_\_\_ Insured ID# \_\_\_\_\_  
Address \_\_\_\_\_ Group \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Owner \_\_\_\_\_ Birth Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Patient Relation to Policy Owner \_\_\_\_\_ Eff date \_\_\_\_\_ Exp \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS.**  
I hereby authorize Pinnacle Radiology to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning my testing. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to myself or my dependents. I understand I am financially responsible for amounts not covered by my health insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Pinnacle Radiology

## INTRAVENOUS CONTRAST INJECTION FORM

Dear Patient:

Your doctor has scheduled you for an examination requiring the injection of iodinated contrast media (dye). There may be some local discomfort associated with the injection of the contrast medium. In some cases, the contrast may cause a hot flushed sensation or nausea. Rarely, more serious complications may occur. **If you are allergic to iodine or have asthma or other allergies, or if you have any kidney function problems, please tell the radiologic technologist.**

### AFTERCARE NOTES

It is extremely rare to have any delayed reaction to the contrast media. However, if you experience a rash, hives, shortness of breath or other symptoms, please contact your doctor right away. You should drink plenty of water in the next 48 hours to help flush the contrast out of your system. If you are diabetic and take glucophage, you should discontinue the glucophage for 48 hours, and contact your physician to determine if they want to draw lab work.

I have read and understand the above and agree to allow the authorized physicians or designee to perform the intravenous contrast examination on:

PATIENT NAME \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Technologist

\_\_\_\_\_  
Date

If the patient is incompetent to give consent because of physical condition or age, please complete the following:

Patient (is a minor \_\_\_\_\_ years of age) (is unable to give consent because)

\_\_\_\_\_

\_\_\_\_\_  
Signature of legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Witness)