



**(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 \_\_\_\_\_



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**DEXA (BONE DENSITY TESTING)**  
**PREPARATION**

**Wear loose fitting clothing, and avoid metal over the abdominal/pelvic area.**

## PINNACLE RADIOLOGY DXA QUESTIONNAIRE

The following questions are necessary to analyze your bones and compare with standards for persons in your ethnic and age group. Other questions relate to your risk for osteoporosis. Please mark the appropriate area with an X. Thank you.

Name \_\_\_\_\_ Date \_\_\_\_\_

Sex F M      Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Height at age 25: \_\_\_\_\_ Age at MENOPAUSE \_\_\_\_\_

Any chance you could be pregnant    Y    N      Last Period \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_

### Ethnic group

White \_\_\_\_\_ African American \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ American Indian \_\_\_\_\_

Have you had a bone density test previously? \_\_\_\_\_ Where \_\_\_\_\_

Have you had a hysterectomy \_\_\_\_\_ Age \_\_\_\_\_ Where the ovaries removed \_\_\_\_\_

Have you been told you have osteoporosis \_\_\_\_\_ Do you take medication for osteoporosis \_\_\_\_\_ Name of medication \_\_\_\_\_

### Do you have any of the following medical conditions:

Thyroid problems \_\_\_\_\_ Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Epilepsy \_\_\_\_\_ Rheumatoid arthritis \_\_\_\_\_

Do you take medication for any of the above conditions? \_\_\_\_\_ Name \_\_\_\_\_

Have you had any surgery on your      HIP \_\_\_\_\_ SPINE \_\_\_\_\_ FOREARM \_\_\_\_\_

Fracture history:

	Patient	Mother
Hip	_____	_____
Spine	_____	_____
Wrist	_____	_____
Other _____	_____	_____

Humped posture \_\_\_\_\_

Loss of Height \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Technologist  
notes \_\_\_\_\_

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