



**(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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## **ULTRASOUND PREPARATION INSTRUCTIONS**

**Plan on your appointment taking 45 minutes**

**Abdomen US-** Nothing to eat or drink 6 hours prior to your exam. You may take medications with small sips of water. Some food can cause the gallbladder to contract, and can make imaging of that organ difficult or impossible. Food and fluids can obscure the pancreas and abdominal aorta.

**Pelvic US-** Drink at least 40 oz of water or non-carbonated drink 1 1/2 hours before you exam time. In the summer, or if you are dehydrated it make take more fluid and a longer time to get your bladder full. **IT IS VERY IMPORTANT THAT YOUR BLADDER IS FULL OF FLUID.** Ultrasound waves need the “water window” to travel through to delineate the pelvic organs. Water or non-carbonated drinks are the best items to drink. Carbonated drinks cause air artifacts in the bowel area, which can obscure important organs.

**Renal US-** Eat and drink normally. Do not void 1 hour prior to your exam.

**Aorta US-** Follow the abdominal US preparation.

**Abdomen and Pelvic US scheduled on the same day** Drink 40 ounces of water (water ONLY) 1 and ½ hours before your exam time. Do not eat anything.

**OB US** Less than 16 weeks, follow the PELVIC US preparation. Greater than 16 weeks, drink 32 ounces of water 1 hour before your examination time. At 16 weeks or more, the baby has enough fluid around it that a very full bladder is not necessary.

**Breast:** Does not require preparation. **IT IS CRITICAL THAT YOU BRING ANY PRIOR MAMMMOGRAMS OR BREAST ULTRASOUND IMAGES WITH YOU TO YOUR APPOINTMENT.**

**None of the following ultrasound examinations require preparation:**

**Thyroid**  
**Testicular**  
**Carotid**  
**Venous Doppler**  
**Extremity US**