Confidential Patient Information

Patient Name:____ Date:_____/_____/_____

Gender: M F Date of Birth: _____/_____/_____ Age _____ SS #_______________________

Home Address:____ Apt#: ____________

City: ______________________________ State:__________ Zip Code: ______________________

Providing your correct phone numbers <u>and e-mail</u> is critically important. We use these to reach you with your test results, any last minute scheduling changes, and other important information from your doctor.

Home Phone: ________________ Cell Phone: __________________ Work Phone: __________________

E-mail #1: ______________________________ E-mail #2:____________________________________

Employer:___________________________________ Occupation: ____________________________

Employer Address: ____

City/State/Zip:____

Name of your Primary Doctor: ____

Location: (street name) ____

May we send your doctor information about your visit here? YES NO

EMERGENCY

(Name and phone number of nearest relative or friend NOT living with you.)

Last Name:____________________________ First Name: __________________________ Middle: _____

Home Number:_____________________________ Work Number: ________________________________

Relation to Patient:____

X-RAY CONFIRMATION & PERSONAL GUARANTEE

1.) This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

____ ____________________

(Patient or Guardian Signature) (Date)

2.) I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

____ ____________________

(Patient or Guardian Signature) (Date)

4247 W Kennedy Blvd Tampa, Fl 33609 813-289-5575