WELCOME TO OUR OFFICE

PLEASE COMPLETE ALL SECTIONS OF THIS INFORMATION FORM

NAME: _____ DOB:_____ S.S.#_____

RACE: ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ CAUCASIAN ☐ AMERICAN INDIAN ☐ HISPANIC/ LATINO ☐ OTHER RACE	ETHNICITY: ☐ HISPANIC/ LATINO ☐ REFUSE ☐ OTHER

ARE YOU A TEMPORARY OR PERMANENT RESIDENT OF A REHAB/NURSING OR ASSISTED LIVING FACILITY? ☐ Y ☐ N

LOCAL ADDRESS: _____

CITY/STATE: _____ ZIP: _____

NORTHERN ADDRESS:_____

CITY/STATE:_____ ZIP:_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

REFERRING PHYSICIAN: _____ EMPLOYER:_____

PRIMARY PHYSICIAN: _____

Do we have permission to leave appointment information on your home answering machine/voicemail/cell phone: ☐ Y ☐ N

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN ABOVE

NAME:_____ HOME PHONE:_____ WORK PHONE:_____

INSURANCE INFORMATION

IS THE INSURANCE THRU YOUR EMPLOYER OR YOUR SPOUSE'S EMPLOYER? ☐ SELF ☐ SPOUSE

IF SPOUSE: NAME:_____

DATE OF BIRTH:_____ SOCIAL SECURITY#:_____

EMPLOYER:_____

IS THIS CLAIM RELATED TO A WORKER'S COMP OR AUTO ACCIDENT? ☐ Y ☐ N DATE_____

IS THERE A POSSIBILITY YOU MAY BE PREGNANT? ☐ Y ☐ N

HOW DO YOU WISH TO PAY TODAY? CREDIT CARD____CHECK____CASH____

I understand and agree, regardless of my insurance status, all deductible and co-payment charges are due at time of service. I further understand that my insurance may not pay for all my health care costs, insurance only pays for covered items and services when their guidelines are met, and insurance may not pay for a particular item or service even though my doctor recommends that I have this done. I am financially responsible for my bill, and any non-covered charges. I have read all the information on this form and have completed the above information as true and correct. If necessary, I authorize RAVE to request office notes from my ordering physician and the release of any medical information needed for my medical care or other information as needed to process the claim.

HOW DID YOU HEAR ABOUT US (CHECK ALL THAT APPLY):

☐ Your doctor ☐ Friend ☐ Walk in ☐ Radio ☐ Newspaper ☐ Billboard
☐ Yellow pages ☐ Other

Please provide your EMAIL address:_____@_____

SIGNATURE:_____ DATE: _____

Radiology Associates of Venice & Englewood
512-516 Nokomis Avenue South, Venice, FL 34285
(941)488-7781 Fax (941)486-0349

Patient Name:_____ DOB:_____Date:_____
Reason for Visit:_____
Referring Dr:_____ Primary Dr:_____

Past Medical History Check (√) all that apply

□ Alcoholism	□ Deep Vein Thrombosis	□ High blood pressure	□ Multiple sclerosis
□ Anemia	□ Diabetes	□ High cholesterol	□ Murmurs
□ Arthritis	□ Emphysema	□ HIV positive	□ Osteoporosis
□ Asthma	□ Epilepsy	□ Insomnia	□ Pacemaker
□ Blood disorders	□ Fracture _____	□ Kidney disease	□ Palpitations
□ Blood Clots	□ GERD	□ Kidney Stones	□ PVD
□ Cancer(Type)_____	□ Glaucoma	□ Liver Cirrhosis	□ Pulmonary Embolism
□ Cataracts	□ Gout	□ Liver disease	□ Sleep Apnea
□ Chemical dependency	□ Heart disease	□ Meningitis	□ Stroke
□ Congestive heart failure	□ Hepatitis	□ Migraine / Headaches	□ Thyroid problems
□ COPD	□ Hernia	□ Mitral Valve Prolapse	□ Tuberculosis

Past Surgical History

Surgery:	Date:	Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History Circle those that apply

Disease:	Relative:	Disease:	Relative:
Diabetes(type)_____	_____	Osteoporosis	_____
Heart Disease	_____	Peripheral Vascular Disease	_____
High Blood Pressure	_____	Cancer(type)_____	_____
Kidney Disease	_____	Cancer(type)_____	_____
Stroke / TIA	_____	Cancer(type)_____	_____

Father: Living / Deceased Age _____ Cause of Death _____
Mother: Living / Deceased Age _____ Cause of Death _____
Brother(s): #Alive_____ #Deceased_____ Sister(s): #Alive_____ #Deceased_____

Social History

Have you ever used tobacco? Yes / No (Type)_____ How often?_____ Year quit?_____
Are you currently taking any herbal drugs? Yes / No Drug name:_____
Do you drink alcohol? Yes / No How much?_____
Do you exercise? Yes / No How often?_____ Duration_____
Occupation: _____ Retired? Yes / No
Marital status: _____ Does anyone else live in your home?_____

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Allergies / Reactions

☐ NONE ☐ MEDICATIONS ☐ LATEX ☐ IV DYE/CONTRAST ☐ PROBLEMS WITH ANESTHESIA

List Allergies and Reactions:

_____

Prescriptions/ Non-Prescription Medications / Vitamins / Supplements

Medication	Dose/# per day	Medication	Dose/# per day
1._____		7._____	
2._____		8._____	
3._____		9._____	
4._____		10._____	
5._____		11._____	
6._____		12._____	

Vaccinations: Influenza Vaccine? Date_____ Pneumonia Vaccine? Date_____

Review of Systems

SYSTEMIC
- ☐ Chills
- ☐ Feeling tired(Malaise)
- ☐ Fever
- ☐ Weight Change
- ☐ Sweats
- ☐ Forgetfulness
- ☐ Headache
- ☐ Other_____

MUSCULOSKELETAL

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle aches
- ☐ Stiffness of the back
- ☐ Neck Stiffness
- ☐ Other_____

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Nausea
- ☐ Black or bloody stools
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Other_____

CARDIOVASCULAR
- ☐ Chest pain or discomfort
- ☐ Rapid heart beat
- ☐ Palpitations
- ☐ Cold hands or feet
- ☐ Varicose veins
- ☐ Leg pain while walking
- ☐ Ankle Joint swelling
- ☐ Other_____

EYE, EAR, NOSE, THROAT
- ☐ Blurred vision
- ☐ Itchy eyes
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Throat pain
- ☐ Difficulty swallowing
- ☐ Other_____

SKIN
- ☐ Bruise easily
- ☐ Itching
- ☐ Rash
- ☐ Other_____

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Other_____

PULMONARY
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other_____

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting (syncope)
- ☐ Vertigo
- ☐ Motor Disturbances
- ☐ Sensory Disturbances
- ☐ Other_____

PSYCHOLOGICAL
- ☐ Difficulty sleeping
- ☐ Anxiety
- ☐ Depression
- ☐ Other_____

ENDOCRINE
- ☐ Excessive sweating
- ☐ Excessive thirst

OFFICE USE ONLY:

BP_____/_____ Pulse_____ 02 SATS_____TEMP_____ RESP_____ HT_____ WT_____