ELITE RADIOLOGY OF GEORGIA

NEW PATIENT INFORMATION

CHART #:_____

ORDERING PHYSICIAN: _____DATE: _____

PATIENT NAME: _____ SEX: ____D.O.B.: _____AGE: _____

ADDRESS: _____SSN: _____-_____-_____

CITY: _____STATE: _____ZIP: _____PHONE: _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER_____ PHONE_____
JOB TITLE_____ DATE LAST WORKED_____
SPOUSE'S NAME_____ SPOUSE'S EMPLOYER_____
EMERGENCY CONTACT_____ PHONE_____

IN ORDER TO PROVIDE THE BEST RESULTS, THE DOCTOR NEEDS TO KNOW ABOUT YOUR PAIN.

CHECK ONE: AUTO ACCIDENT_____ WORK RELATED INJURY_____ OTHER_____

DATE OF ACCIDENT OR INJURY: _____

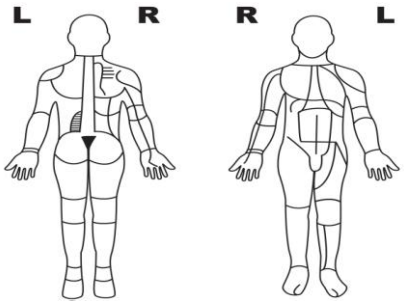
PLEASE CHECK IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

HEADACHES: YES ____ NO ____ FREQUENCY_____ SEVERITY_____

RADICULOPATHY: YES ____ NO ____ (numbness/pain from the shoulder-fingers or hips-feet)
RIGHT ARM____ LEFT ARM____ RIGHT LEG____ LEFT LEG____

INDICATE WHERE YOUR PAIN IS LOCATED BY MARKING AREA ON THE DIAGRAM.

HEIGHT_____ **WEIGHT**_____



_____ _____
Patient Signature Date Technologist Signature Date

March 2016