



PATIENT INFORMATION

Medical Record# _____ - _____

Last Name: _____ First: _____ MI: _____

Birth date: _____ Gender: M F E-Mail Address: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Alternate Ph#: _____ Work / Cell

Social Security #: _____ Marital Status: _____

(Used only for internal identification purposes. Is not given out or displayed)

How did you hear about us? Did your doctor tell you about us or did you hear about it from another source?

Employer: _____ Work Phone: _____

Employer's Address: _____

City, State, Zip: _____

Referring Physician: _____

EMERGENCY CONTACT: Name of a friend or relative not living with you:

Name: _____ Ph#: _____

Address: _____

City, State,

Zip: _____ Relationship: _____

DISCLAIMER:

I understand that these scans constitutes EBCT imaging of the coronary arteries, thorax (non-contrast), abdomen/pelvis(oral contrast) and/or the colon (air contrast). The results will be mailed to my referring physician within 8-10 business days. I will make arrangements to go over the test results with my referring physician. All scans performed are considered to be for screening purposes. Insurance may or may not reimburse for services.

PAYMENT TERMS:

LIFETEST does not currently participate with any insurance companies, payment is expected at time of service. I understand that I am responsible to file any insurance claims if I so desire. I hereby authorize LIFETEST to release any medical information necessary to process any related insurance claims if such request is made.

Patient Signature

Date