Georgia Health Imaging
3653 Lawrenceville Highway Suite 150
Lawrenceville, GA • 30044
Tel: 678-924-0964 • Fax: 678-924-0965
ACR Accredited
Advanced Diagnostic Technology at Your Convenience

Thank you for choosing Georgia Health Imaging as your imaging provider.
Please fully complete this form so that we may serve you better.

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
SSN: _____-_____-_____ Marital ☐ Single Home: (_____)_____-_____
Age: _____ Status: ☐ Married Work: (_____)_____-_____
Date of Birth: _____/_____/_____ ☐ Divorced Cell: (_____)_____-_____
Sex: ☐ Male ☐ Female ☐ Widowed Email: _____
Address: _____ City: _____ State: _____ Zip:_____
Employer: _____ Emergency Contact: _____
Employer Phone: (_____)_____-_____ Emergency Contact Phone: (_____)_____-_____

PRIMARY INSURANCE

Insurance Name: _____ Policy #: _____
Address: _____ Group#: _____
City: _____ State: _____ Zip: _____ Insurance: (_____)_____-_____
Policy Holder Information (If different from patient)
Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip:_____
Employer: _____ Employer Phone: (_____)_____-_____
Address: _____ City: _____ State: _____ Zip:_____
SSN: _____-_____-_____ Date of Birth: _____/_____/_____
Home: (_____)_____-_____Cell: (_____)_____-_____

OR

☐ Self Pay Patient
☐ Worker's Compensation

How did you hear about Georgia Health Imaging?
☐ Doctor ☐ Friend ☐ Insurance Company ☐ Yellow Pages ☐ Kudzu.com
☐ Linked In ☐ Facebook ☐ Twitter ☐ Other:_____

In The Event that my Insurance denies payment for services rendered by GHI, I agree to Personally and fully be responsible for the cost of my examination.

Name: _____ Signature: _____ Date: _____

Accepted by:_____
Date: _____

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CONSENT TO EXAMINATION

I,_____, hereby give my full consent for medical diagnostic procedures to Georgia Health Imaging and its staff and understand that procedures may, at times, require physical contact with intimate parts of the body. If at any time I feel uncomfortable during the performance of any diagnostic procedure, I can inform the doctor and/or technologist of my discomfort. The doctor and/or technologist will attempt to lessen my discomfort as permitted by the procedure required.

_____ _____
PATIENT/PARENT SIGNATURE DATE

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received, read, and understood Georgia Health Imaging's Notice of Privacy Practices.

_____ _____ _____
NAME OF PATIENT/PARENT SIGNATURE DATE

_____
RELATIONSHIP TO PATIENT (if applicable)

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign.
_____Communications barriers prohibited obtaining the acknowledgement.
_____An emergency situation prevented us from obtaining acknowledgement.
_____Other. Specify:_____
_____
_____

Accepted by:_____
Date: _____

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Name: _____Age:_____ Birthday: _____ Sex: Female/Male

Present History Concerns:
_____
_____

Medications:_____
_____
_____

Allergies or Reactions to medications/foods/other:
_____
_____

Personal Medical History:
_____
_____

Past History:
_____
_____

Surgical History:
_____
_____

Family History:
_____
_____

Social History:
Tobacco Use?
Cigarettes: Cigar: Chew:
Never:
Quit date: _____

Alcohol Use:
Do you drink? No / Yes

Do you use any recreational drugs?
No / Yes

_____ _____
Signature Date

Accepted by:_____
Date: _____