VRI
VALLEY RADIOLOGY
MEDICAL ASSOCIATES, INC.
A Radnet Center™

**VRI Mountain View Imaging Center**
**285 South Drive, Suite 5**
**San Jose, CA 94040**
**Phone: (650) 967-1331**
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# PATIENT INFORMATION FORM

| | | |
|---|---|---|
| Last Name: | First Name: | Middle Name: |
| MRN: | DOB: | Gender: |
| Address 1: | | |
| Address 2: | | |
| City: | State: | Zip Code: |
| Home Phone: | Work Phone: | Cell Phone: Email: |
| Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail | | |
| Preferred Delivery Method: ☐ Mail ☐ Electronic | Preferred Language: | |
| Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian | | |
| Are you: ☐ Hispanic ☐ Not Hispanic | Referring Physician: _____ | |

## RESPONSIBLE PARTY INFORMATION

| | | |
|---|---|---|
| Last Name: | First Name: | |
| Patient's Relationship to Responsible Party: | | Phone: |
| Address 1: | | |
| Address 2: | | |
| City: | State: | Zip Code: |

## Primary Insurance Information

| | | |
|---|---|---|
| **For Medicare Patients: Are You or Your Spouse Working?**: ☐ YES ☐ NO | | If Yes, whom? |
| Primary Insurance Name: | | Plan Name: |
| Address: | | |
| City: | State: | Zip: |
| Policy #: | Group #: | DOB: |
| Policy Holder Name: | | Sex: |
| Policy Holder Address: | | |
| City: | State: | Zip: |
| Patient's Relationship to Policy Holder: | | |

## Secondary Insurance Information

| | | |
|---|---|---|
| **For Medicare Patients: Are You or Your Spouse Working?**: ☐ YES ☐ NO | | If Yes, whom? |
| Primary Insurance Name: | | Plan Name: |
| Address: | | |
| City: | State: | Zip: |
| Policy #: | Group #: | DOB: |
| Policy Holder Name: | | Sex: |
| Policy Holder Address: | | |
| City: | State: | Zip: |
| Patient's Relationship to Policy Holder: | | |

## MEDICAL INFORMATION

| | | |
|---|---|---|
| Is this visit related to an auto accident? | ☐ Yes | ☐ No |
| Is this visit related to an injury sustained while at work? | ☐ Yes | ☐ No |

Date of Injury: _____/_____/_____ Height: _____ ft. _____ in. Weight: _____

**SMOKING STATUS:**

☐ Current Every Day ☐ Current Some Days ☐ Never smoked ☐ Smoker, current status unknown ☐ Former smoker ☐ Unknown

**ACTIVE MEDICATIONS: ☐ None**

| | | | |
|---|---|---|---|
| ☐ ActoPlus Med | ☐ Fortamet | ☐ Glyburid Met | ☐ PrandiMet |
| ☐ Avandamet | ☐ Glucophage | ☐ Janumet | ☐ Riomet (liquid form of Metformin) |
| ☐ Diabex | ☐ Glucovance | ☐ Metaglip | |
| ☐ Diafomin | ☐ Glumetza | ☐ Metformin | |

**MEDICAL HISTORY: ☐ None**

| | | | |
|---|---|---|---|
| ☐ Aneurysm Clip / Coil | ☐ Breast Implants | ☐ Insulin Pump | ☐ Parplegic |
| ☐ Aneurysm **Had Surgery** | ☐ Cancer | ☐ Metal In the Body | ☐ Previous CT Contrast Reaction |
| ☐ Aneurysm **NO Surgery** | ☐ Diabetes | ☐ Morphine Pump | ☐ Previous MR Contrast Reaction |
| ☐ Asthma | ☐ Hypertension | ☐ Pacemaker | ☐ Renal Disease |

**ALLERGIES: ☐ None**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Adhesive Tape | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Latex | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Bee Sting | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Lidocaine / Novacaine | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Betadine (Topical Iodine) | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Mold | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Contrast (Med. Imaging) | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Peanut or other nut | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Dog, Cat, or Animal | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Penicillin | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Dust | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Rubbing Alcohol | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Fruit | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Shellfish | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Grass / Pollen | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Sulfa Drug | ☐ Mild | ☐ Moderate | ☐ Severe |

**Mild allergic reactions** include hives, itching, nasal congestion, rash and watery eyes.
**Moderate allergic reactions** include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomitting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconciousness.
**Severe allergic reaction** is anaphalytic shock.

**TO OUR FEMALE PATIENTS**

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

_____ _____
*Signature* *Date*

Date of Last Menstrual Period: _____/_____/_____

**AUTHORIZATION & AGREEMENT**

**I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.**

_____ _____
*Signature of Patient, or Personal Representative* *Date*