BLUE STAR IMAGING | AT THE STAR
3800 GAYLORD PARKWAY | SUITE 150 | FRISCO, TEXAS 75034
PHONE: 972.497.4100 | FAX: 972.497.4104

PATIENT DEMOGRAPHICS

Patient's First Name: _____ M.I. _____ Last Name: _____

DOB: _____ ☐ Male ☐ Female SSN: _____

Street Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Referring Physician: _____

PLEASE SELECT ONE OF THE FOLLOWING:

☐ Insured ☐ Uninsured ☐ Workers' Compensation ☐ Other _____

IF YOU ARE INSURED, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Insurance Carrier: _____ Group Number: _____

Policy | Member Number: _____ Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's SSN: _____

Subscriber's Date of Birth: _____ Subscriber's Employer _____

_____ _____

Patient | Parent | Leagal Guardian Signature **Date**

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X-RAY SCREENING FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female Weight: _____ Height: _____

What symptoms are you experiencing? _____

Referring Physician: _____

Have you had surgery to the area we are imaging today? ☐ **YES** ☐ **NO**

Have you had prior imaging studies that relate to today's current problem? ☐ **YES** ☐ **NO**

If yes, please describe what type of imaging and what facility:

_____

_____

FEMALE PATIENTS ONLY

☐ **Yes** ☐ **No** Is there a chance that you are pregnant?
☐ **Yes** ☐ **No** Are you currently pregnant?
☐ **Yes** ☐ **No** Have you had a hysterectomy or tubal ligation?
☐ **Yes** ☐ **No** Are you currently nursing?

What is the date of your last menstrual cycle? _____ To _____

I have informed the technologist that I am NOT pregnant at this time.

Signature: _____ Date: _____

FORM OF BIRTH CONTROL

☐ Abstinence
☐ Birth Control Pills/Patch
☐ Diaphragm
☐ Vasectomy
☐ Condom
☐ IUD
☐ Menopause
☐ None

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

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HIPAA ACCESS TO PROTECTED HEALTH INFORMATION

Have you had a prior imaging study on the body part you are having examined today? ☐ Yes ☐ No

If yes, what type of exam (circle all that apply) CT MRI ULTRASOUND X-RAY

Name of facility where exam was performed: _____

Date of Service: _____

I hereby authorize Blue Star Imaging to request protected health information on my behalf for comparison purposes.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Please Note:

At the request of your primary care physician or referring doctor, your health information and images may be visible to other physicians for continuing your patient care. The purpose of the request could be for a consultation, second opinion, and/or referral to a specialist.

It is to be understood by all parties that the permitted uses and disclosures of health information must be within the scope of the obligations and responsibilities for continued medical care, defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ By initialing here, you are helping streamine the process and allowing the consulting physician to view your images without further consent.

If you wish NOT to have your images available for continued care, please let the front desk know and we will note your account accordingly.

In addition to the caregiver(s) providing services and my insurance company for payment of claims, I would like for the following person(s) to have access to my protected health information (PHI).

Name(s)	**Relationship to Patient**
_____	_____
_____	_____