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 | Legal Guardian Signature **Date**

BLUE STAR IMAGING | **AT THE STAR**
3800 Gaylord Parkway | Suite 150 | Frisco, Texas 75034
Phone: 972.497.4100 | Fax: 972.497.4104

CT SCREENING FORM

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

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

What symptoms are you experiencing? _____

Referring Physician: _____

ARE YOU DIABETIC OR HAVE RENAL DISEASE? ☐ YES ☐ NO **CLAUSTROPHOBIC?** ☐ YES ☐ NO

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

☐ Yes ☐ No Have you ever had IV contrast (dye) injection in the past? (Cardiac Cath, CT, MRI, other)
☐ Yes ☐ No Are you allergic to iodine or an iodine containing substance? _____
☐ Yes ☐ No Do you have both kidneys? _____
☐ Yes ☐ No Do you have asthma or lung disease? _____
☐ Yes ☐ No Have you been diagnosed with hepatitis or jaundice? _____
☐ Yes ☐ No Have you been diagnosed with epilepsy or seizure disorder? _____
☐ Yes ☐ No Do you have high blood pressure (hypertension)? _____
☐ Yes ☐ No Do you have heart disease? _____
☐ Yes ☐ No Do you have a history of cancer? If yes, explain: _____
☐ Yes ☐ No Have you been diagnosed with Multiple Myeloma? If yes, explain: _____
☐ Yes ☐ No Do you have a history of stroke? _____

DO YOU HAVE ANY DRUG ALLERGIES? IF YES, PLEASE LIST MEDICATIONS BELOW: ☐ YES ☐ NO

_____

LIST PREVIOUS SURGERIES AND APPROXIMATE DATES:

_____

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?

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: _____

BLUE STAR IMAGING | **AT THE STAR**
3800 Gaylord Parkway | Suite 150 | Frisco, Texas 75034
Phone: 972.497.4100 | Fax: 972.497.4104

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**
_____	_____
_____	_____