

Prestonwood Imaging Center

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Plano, Texas 75093

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CT Patient Information

Name: _____ Date: _____

Address/City/State/Zip: _____

DOB: _____ SSN: _____ Height / Weight _____

Sex: Male / Female Referring Physician _____

Have you had any previous studies that pertain to your problem, within the last 12 months?

_____ *MRI* When/Where? _____

_____ *CT* When/Where? _____

_____ *X-RAYS* When/Where? _____

Please list any surgeries that you have had in your lifetime:

Please list all medications that you are currently taking: _____

Why are you here today for this exam? _____

I authorize the release, by Prestonwood Imaging Center, for any medical information and/or films necessary to process claims for payment; the release to other physicians or medical facilities as designated by me and/or to obtain previous reports and/or films to aid in our radiologist's interpretation of results.

Patient's Signature: _____ Date: _____

I authorize direct payment of all medical benefits to Prestonwood Imaging Center.

Patient's Signature: _____ Date: _____