

**Prestonwood Imaging Center**  
6957 West Plano Parkway, Suite 1100  
Plano, Texas 75093  
Office 972.395.7533 Fax 972.395.7536

**PATIENT HISTORY AND SCREENING QUESTIONNAIRE**

**PATIENT INFORMATION**

**DATE**

Patient Name \_\_\_\_\_ Sex M / F Weight \_\_\_\_\_ Height \_\_\_\_\_

Phone # \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ Procedure \_\_\_\_\_

Referring Physician \_\_\_\_\_ Are you pregnant? YES / NO / Date of last period \_\_\_\_\_

What is the reason you are here today? Explain your medical problem in detail please.  
(What is the problem? Where is your problem? How long have you had this problem?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a previous imaging study related to his problem? (X-ray, ultrasound, MRI/CT? **YES / NO** If yes, please explain \_\_\_\_\_  
What exam? \_\_\_\_\_ When? \_\_\_\_\_ Name of facility \_\_\_\_\_

List other medical problems \_\_\_\_\_

List previous surgeries \_\_\_\_\_

What medications are you presently taking? \_\_\_\_\_

List any drug/latex or food allergies \_\_\_\_\_

Do you smoke? **YES / NO** If yes, for how long? \_\_\_\_\_ Packs per day \_\_\_\_\_

Do you have pain presently? **YES / NO** Where is your pain? \_\_\_\_\_

How long have you has this pain? \_\_\_\_\_

Pain Rating/Intensity; (1= least amount of pain, 10= unbearable pain)

1 2 3 4 5 6 7 8 9 10

ACKNOWLEDGEMENT: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am/am not, pregnant at this time. I give consent to perform my ultrasound at Prestonwood Imaging

I authorize the release by Prestonwood Imaging Center 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 Radiologists interpretation.

Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_

**Patient/Parent/Guardian  
signature** \_\_\_\_\_

**TECHNOLOGIST INITIAL** \_\_\_\_\_

**DATE** \_\_\_\_\_

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Clinic: 519

## FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(please sign here-Patient or Responsible Party)

Responsible Party Name: \_\_\_\_\_  
(please print name of Responsible Party if different from Patient)

Attention: Prestonwood Patients!!!!

24-48 Hours after your procedure, your primary care Doctor will receive a report. In order to get your results, you must consult your Doctor. Should you choose to see a Specialist or get a second opinion, you are responsible for calling us 48 hours in advance in order to request your films and report. In order to provide the best service possible to you and your Doctor, we need your cooperation. Please let us know how we may assist you.

THANK YOU

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_