alinea | MEDICAL IMAGING

ULTRASOUND PATIENT FORM

CONTACT: (909) 622-3166

Last: ____________ First: ____________ MI: ______

Address: ____________ Apt# ______ DOB: ____________ SEX: ☐ Male ☐ Female

City: ____________ State: ______ Zip: ______ Email: ____________

Phone: (   ) ____________ SS#: ____________ Referred By: ____________

METHOD OF PAYMENT: *(Circle one)* **Insurance** **Medi-Cal** **Medicare** **Cash** **Bill Doctor/Clinic**

Have you ever had an exam with us before? ☐ Yes ☐ No

Is this your first ultrasound? ☐ Yes ☐ No If no, when and where have you had an exam? ____________

FOR WOMEN ONLY:

Please answer all that apply:

Are you currently pregnant? **YES / NO**

Do you have any abnormal vaginal bleeding? **YES / NO**

Do you have any abnormal pelvic pain or cramping? **YES / NO**

Date of last menstrual period: ____________

How many pregnancies had you had? ______

How many Live Births: ______

Have you had a hysterectomy. If yes, what age? ______

ASSIGNMENT AND RELEASE:

I hereby assign my insurance benefits to be paid directly to Alinea Medical Imaging. I accept responsibility for non-covered services. I also authorize Alinea Medical Imaging to release information to my insurance carrier to process this claim.

RELEASE OF MEDICAL RECORDS:

I hereby authorize Alinea Medical Imaging to release my films and reports to any requesting physician or medical facility providing my medical care for continuing treatment in my health care. This authorization will remain in effect for 1 year from the date of my signature.

X: ____________ **Date:** ______

OFFICIAL USE

MRN: ____________ Date of Exam: ____________

ACC: ____________

Tech: ____________ TA: ____________

NECK & CHEST

☐ **76536** Thyroid OR Head/Neck Soft Tissue

☐ **76604** Chest

VASCULAR

☐ **93880** Carotid Arterial BILAT

☐ **76775** Abdominal Aorta

☐ **93970** Venous Doppler BILAT **Lower / Upper**

☐ **93971** Venous Doppler UNILAT **Lower / Upper** **L / R**

EXTREMITIES

☐ **76882** Non vascular Extremity

OTHER

CPT: ____________

Description: ____________

ABDOMEN & PELVIS

☐ **76700** Abdomen – Complete

☐ **76705** Abdomen – Limited (specify):

☐ **76770** Renal/Retroperitoneal Complete (kidneys + bladder)

☐ **76775** Retroperitoneal Limited (Abdominal Aorta)

☐ **76830** Pelvis - Non-OB/Transvaginal

☐ **76856** Pelvis - Non-OB/Transabdominal/Male Pelvis

☐ **76857** Pelvis - Limited

☐ **76872** Prostate - Transrectal

☐ **76870 +93976** Scrotal with Doppler

OBSTETRIC

☐ **------** Fetal Sex Only

☐ **------** Fetal 3D (Non Diagnostic)

☐ **76801** Fetal OB - 1st Trimester (<14 weeks)

☐ **76802** Fetal OB (each additional gest <14 weeks)

☐ **76805** Fetal OB - 2nd/3rd Trimester (>14 weeks)

☐ **76810** Fetal OB (each additional gest >14 weeks)

☐ **76813** OB Nuchal Translucency

☐ **76815** Fetal OB Limited

☐ **76816** Fetal OB Follow-up

☐ **76817** OB Transvaginal