



180 NORTH DEAN STREET • ENGLEWOOD, NJ 07631
TEL: 201.568.4242 • FAX: 201.568.1298
WWW.BERGENIMAGINGCENTER.COM
CHRISTOPHER L. PETTI, MD
ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

Account # _____ Today's Date _____

Name: Last _____ First _____

Date of Birth _____ Age _____

Type of Ultrasound _____

Send report to the following Physician _____

Are you pregnant? _____

What is the reason for having this exam? _____

Previous Radiology Tests of area of concern? _____ Where? _____

Any history of Cancer? _____

Any family history of Cancer of concerned area? _____

Family History of AAA (pt having screening Ultrasound of AAA only) _____

List current medications _____

Do you or have you ever smoked tobacco? _____

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam

Patient's signature _____ Date: ___ / ___ / ___

NOTE: If you have previous films or reports with you, please give them to the receptionist before your exam