BERGEN IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

GENERAL ULTRASOUND REGISTRATION FORM

TECHNICIAN INITIALS

□ GS □ JD □ DD

Account #: _____ Today's Date: _____

Name: Last _____ First_____

Date of Birth: _____ Age: _____

Type of Ultrasound: _____

Send report to the following Physician:

_____

_____

Are you pregnant? □ Yes □ No

What is the reason for 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 (patient 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 discs and/or reports with you, please give them to the receptionist before your exam.