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

GENERAL ULTRASOUND REGISTRATION FORM

TECHNICIAN INITIALS

US: □ JD □ DH □ DB

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 studies of area of concern? _____ Where? _____

Any personal history of cancer? _____

Any family history of cancer? _____

Family history of AAA (patient having screening ultrasound of AAA ONLY) _____

List any medical conditions relating to testing site: _____

_____

List any prior surgical procedures: _____

List current medications: _____

_____

Are you allergic to **LATEX**? □ Yes □ No

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 upon check-in.