MH R&M MURRAY HILL
RADIOLOGY AND MAMMOGRAPHY
NEW YORK PRIVATE MEDICAL IMAGING

New York Private Medical Imaging
MURRAY HILL
650 FIRST AVENUE 2ND FLOOR
NEW YORK, NY 10016
Phone: (212) 686-4440
Fax: (212) 683-3092

PATIENT INFORMATION FORM

Last Name: First Name: Middle Name:

MRN: DOB: Gender:

Address:

City: State: Zip Code:

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Delivery Method: ☐ Mail ☐ Electronic Preferred Language:

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Other Pacific Islander ☐ White / Caucasian

Are you: ☐ Hispanic ☐ Not Hispanic

Referring Physician:

I attest that within the last 30 months, I have seen and am a patient of the physician listed above, to whom I would like you to send today's radiology report.

Signature _____

RESPONSIBLE PARTY INFORMATION

Last Name: First Name:

Patient's Relationship to Responsible Party: Phone:

Address:

City: State: Zip Code:

Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: Plan Name:

Policy #: Group #:

Policy Holder Name: Sex:

Patient's Relationship to Policy Holder: DOB:

Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: Plan Name:

Policy #: Group #:

Policy Holder Name: Sex:

Patient's Relationship to Policy Holder: DOB:

MEDICAL INFORMATION

Is this visit related to an auto accident? ☐ Yes ☐ No Is this visit related to an injury sustained while at work? ☐ Yes ☐ No

Date of Injury: _____/_____/_____ **Height:** _____ ft. _____ in. **Weight:** _____

SMOKING STATUS:

☐ Current Every Day ☐ Current Some Days ☐ Never smoked ☐ Smoker, current status unknown ☐ Former smoker ☐ Unknown

ACTIVE MEDICATIONS: ☐ None *(It is not necessary to document medications not listed)*

☐ ACTOplus Met	☐ Fortamet	☐ Glyburide-metformin	☐ Metaglip
☐ Avandamet	☐ Glucophage	☐ Glycomet	☐ Metformin
☐ Diabex	☐ Glucovance	☐ Janumet	☐ PrandiMet
☐ Diaformin	☐ Glumetza	☐ Kombiglzexr	☐ Riomet (liquid form of Metformin)

MEDICAL HISTORY: ☐ None *(It is not necessary to document history not listed)*

☐ Aneurysm Clip / Coil	☐ Breast Implants	☐ Insulin Pump	☐ Paraplegic
☐ Aneurysm **Had Surgery**	☐ Cancer	☐ Metal In the Body	☐ Previous CT Contrast Reaction
☐ Aneurysm **NO Surgery**	☐ Diabetes	☐ Morphine Pump	☐ Previous MR Contrast Reaction
☐ Asthma	☐ Hypertension	☐ Pacemaker	☐ Renal Disease

ALLERGIES: ☐ None *(It is not necessary to document allergies not listed)*

☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	☐ Latex	☐ Mild	☐ Moderate	☐ Severe
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novocaine	☐ Mild	☐ Moderate	☐ Severe
☐ Betadine (Topical Iodine)	☐ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe
☐ Contrast (Med. Imaging)	☐ Mild	☐ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	☐ Moderate	☐ Severe
☐ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	☐ Moderate	☐ Severe
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	☐ Moderate	☐ Severe
☐ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe

Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes.
Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness.
Severe allergic reaction is anaphylactic shock.

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

_____ _____
Signature *Date*

Date of Last Menstrual Period: _____/_____/_____

AUTHORIZATION & AGREEMENT

Commercial Patients and Medicare Patients of Dr. Mitnick:
Murray Hill Radiology and Mammography does not participate with any medical insurance plans except United Healthcare NYU School of Medicine and NYU Hospital Groups and is opted out of Medicare for Dr. Mitnick. Payment in full is due at the time of service. We accept cash, Check or credit cards. Upon request, we will provide you with the necessary documentation so that you may submit an out-of-network claim to your commercial insurance carrier (excluding Medicare/ Medicaid). If I am BEING SEEN OUT OF NETWORK or UNINSURED, I understand that I am fully responsible for all charges. I also hereby authorize the provider to use, disclose or obtain any of my personal health information for treatment and payment.

UHC NYU School of Medicine and NYU Hospital Groups:
I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. Co-pays and deductibles must be paid at the time of service. I agree to pay the balance of charges not paid under my plan. If I am BEING SEEN OUT OF NETWORK or UNINSURED, I understand that I am fully responsible for all charges. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment.

_____ _____
Signature of Patient, or Personal Representative *Date*

Patient: _____ **DOB:** _____ **MRN:** _____ **Date of Service:** _____