Santa Barbara Women's Imaging Center – Patient Information Sheet

Patient: _____
Last Name *First Name* *M.I.* *DOB* *Age* *Gender*

Address: _____
Street / P.O. Box *City* *State* *Zip Code*

Phone: _____ **Preferred:** ☐ Home ☐ Cell ☐ Other: _____
Home *Cell*

Email: _____

How would you prefer to be contacted regarding the billing on your account? ☐ Email ☐ Text ☐ Phone

Referring Physician: _____

Other physicians you would like to receive a report of today's examination(s):

_____

Is your examination today related to an injury at work? ☐ Yes ☐ No

(Female patients) Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Notice of Privacy Practices and Use of Contact Information
I have received a copy of the Notice of Privacy Practices from Santa Barbara Women's Imaging Center concerning how the use and disclosure of Protected Health Information is handled by this practice. I also acknowledge and consent that SBWIC may use any phone number or email I provide to remind me of appointments and communicate with me concerning services provided and billing matters.

Initial: _____

I have reviewed the information above and confirm that it is accurate.

_____ **Date:** _____
Patient signature (or legal guardian)

Office use:

☐ MR ☐ CT ☐ Mam ☐ US ☐ Vas ☐ Dexa ☐ XR-Fl

Creatinine: _____ *(if applicable)*

Registered by: _____ Time: _____ MU:_____

Cash ☐ Check #_____ Payment Notes: _____

Credit Card Amount Paid $_____ _____

Copay ☐ Deductible ☐Co-Insurance ☐ Paid in Full _____