PATIENT HISTORY AND SAFETY SCREENING

Please check any of the below items if applicable to you:

_____ History of allergic reaction to X-ray/IVP/iodinated dyes or contrasts

_____ Allergy to other medications

_____ Other allergies

_____ Asthma, any form

_____ Sickle Cell Anemia

_____ Kidney failure

_____ High Blood Pressure (Hypertension)

_____ Diabetes (High Sugar)

_____ Pacemaker/ Defibrillator

_____ Neurostimulator

_____ Possibility of Pregnancy?

_____ Hearing Aids

Any other Mechanical Implants not listed above: _____

Is your scan today part of any clinical research study associated with the Center for Medicare and Medicaid Services? Yes or No

_____ _____

Patient / Legal Guardian Date

_____ _____

Witness Date

GRIFFIN IMAGING

220 Rock Street

Griffin, GA 30224

(770) 229-4660

Fax: (770) 229-4632

Specializing In High Field MRI, CT, Ultrasound & Bone Density Scans
www.griffinimagingradiology.com

RECORD RELEASE FORM

I hereby request and authorize Griffin Imaging, LLC to obtain copies of my medical records and/or x-ray films from _____.

Patient Name: _____

Date of Birth: _____

SSN: _____

Pt Acct #: _____

Exam: _____

Date of Service:_____

Referring Phys.:_____

Please fax any and all records pertaining to the above listed date of service and exam to Griffin Imaging, Attention: Dr. Ronald C. Gay at (770) 229-4632.

_____
Patient Signature

_____
Date

_____
Witness

_____
Date