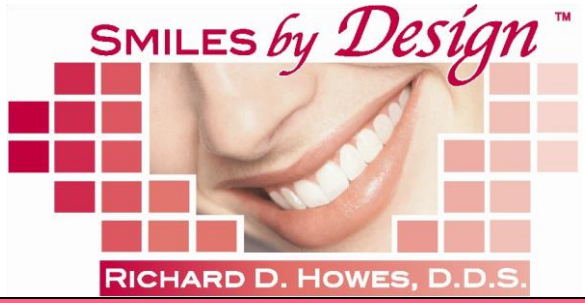

2165 Fourth St. Livermore, CA 94550 (925)443-4182

CT SCAN PATIENT REGISTRATION AND CONSENT FORM

Please fill in the following information and provide your initials and signature at the bottom to confirm consent

***Patient Information**:*

Patient Name:_____

Date of Birth_____ /_____/ _____ Gender (M/F): _____

Name of Doctor requesting CT-Scan:_____

***Contact Information**:*

Address: _____
House / Apt# Street City State Zip

Phone: (Home): _____ Work: _____ Cell: _____

eMail Address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Medical History:
Have you been a patient here before? _____

Have you had a diagnostic scan of the area done previously? Yes _____ No _____
If yes (circle one): MRI CT X-Ray

Where? _____ When? _____

Pacemaker? Yes _____ No _____ Latex Allergies? Yes _____ No _____

(***For Females)*** Is there a possibility you may be pregnant? Yes _____ No _____

CONSENT FOR TREATMENT: (Please Initial)
_____ I consent to the diagnostic imaging procedures deemed necessary by Dr. _____

_____ I understand that I have to pay the amount of $ _____ for the CT scan today.

The I CAT cone beam CT scanner procedures images that are intended only for evaluation of the mandibular and maxillary jawbones. This study is insufficient to detect intracranial and soft tissue disease process.

_____ _____
Patient or Patient Representative Signature Date