VIASCAN of LAS COLINAS

Patient Registration Form

Last Name		First Name		Middle Initial	Age
Date of Scan	**Phone number that you want us to call regarding your appointment**			**Date of Birth**	
Gender: Please circle one ☐ Male ☐ Female** **Women under 50, please complete additional "Questionnaire for Women Under Age 50"			**Height**	**Weight**	
Mailing Address	**City**		**State**	**Zip Code**	
Email Address					
Employer		**Occupation/Job Title**		**How Long?**	
Personal/Primary Care Physician Name		**Physician Phone**	**Physician Fax Number:** (Please list if you want your doctor notified of scan results)		
Physician Address	**Physician City**	**Physician State**	**Physician Zip Code**		
Prescriptions will be needed for ALL scans for men under age 40 and women under age 45, ALL Virtual Colonoscopies (VCs), and ALL Heart Angiograms. **If you meet this criteria, have you faxed prescription from your **physician to ViaScan at 972-739-2854 before your appointment?** ☐Yes ☐ No **Prescriptions must be completed by an MD, DO, PA, or NP					
Have You Ever Had An Electron Beam Tomography (EBT) Scan Done Before? ☐Yes ☐ No		**If so, where and when did you have it done?**	**If so, would ViaScan be able to get a copy of your previous scan?** ☐Yes ☐ No ☐ N/A		
If you have prior scans, can you please bring them to your appointment? ☐Yes ☐ No ☐ N/A		**When Was The Last Time You Had Blood Work Done?**	**Are You Allergic to Any Medications or Contrast Material?** ☐Yes ☐ No ☐ I don't know		

Patient's Primary Concern(s):

☐ Chest Pain or Discomfort ☐ High Cholesterol ☐ High Blood Pressure
☐ Shortness of Breath ☐ Excess or Over Weight ☐ Tobacco/E-Cig Use
☐ Diabetes ☐ Sedentary Lifestyle ☐ Family History of Heart Disease
☐ Other ____

I hereby authorize ViaScan of Las Colinas to furnish to the aforementioned referring physician any reports and/or films pertaining to services rendered or treatment given for the purpose of review or evaluation of Computerized Tomography (CT) test results. Further, if any medical documentation is required, I authorize ViaScan of Las Colinas to request this information on my behalf per the HIPPAA Guideline.

I hereby certify that all information on the form is correct and agree to the stated allegation.

Signature: ______________________________ Date: ____________________

_____ *Please initial here if you DO want us to fax the results to your doctor*

_____ *Please initial here if you DO NOT want us to fax the results to your doctor*

Extras Available: **CD – ROM: $25** **Y** **N** **Cholesterol Screen: $25** **Y** **N**