3909 WARING ROAD, SUITE C
OCEANSIDE, CA 92056
PHONE (760) 630-0014
FAX (760) 630-0015

REGENTS IMAGING

Last Name_____________________________ First_____________________ MI______SEX_____AGE________

Date of Birth______/______/______ Weight_____________

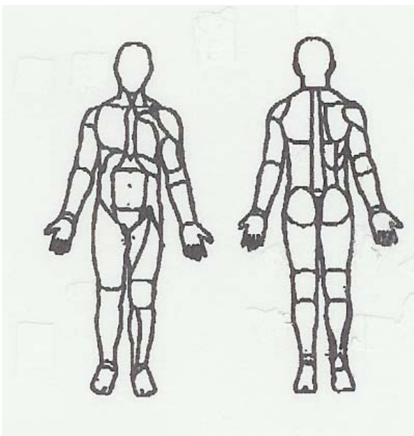
Address____________________________________ City__________________State_______ZIP______________

Home Phone(   )______________________________Work Phone (   )___________________________

Employer ____

Date of Accident _________________________________Work Related?_____________Auto?_______________

Referring Physician__________________________________ Primary Physician___________________________



Please explain your symptoms or the reason you are having this exam. You can use the figures to the left to indicate pain or symptoms:

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____

Have you had any surgery? If yes, please list what type and dates: __________________________________

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____

Do you have any personal history of cancer? If yes, please describe: _________________________________

____

____

Any previous relevant imaging study (MRI, CT, Xray or Ultrasound)? If yes, please specify study, list facility and date.____

____

Do you have any clinical history that would be helpful to radiology staff? If yes, please describe: _________

____

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____ ____

Patient name (Please print) Patient / Parent Signature Date