Medical Imaging
Of Lehigh Valley, P.C.
Interventional Radiology
Diplomates of the American Board of Radiology

James A. Newcomb, M.D.
Darryn I. Shaff, M.D.
Errin J. Hoffman, M.D.
Stephen J. Huber, M.D.
Mark D. Swank, M.D.
Dana R. Burke, M.D., FSIR, FAHA
Neil V. Patel, M.D.

Complete All Questions – Please Print

Date: _____

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: S M W D Spouse Name: _____ DOB: _____

Occupation: _____ Religion: _____

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ Other _____

Language Preference: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Preferred Blood Work Lab: _____ Phone Number: _____

Do you have an Advanced Director or Living Will for Health Care? ☐ Yes ☐ No (if yes, please provide copy)

Primary Insurance:

Insurance Name: _____ Policy #: _____

Insurance Phone: _____

Secondary Insurance:

Insurance Name: _____ Policy #: _____

Insurance Phone: _____

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Patient Name: _____

Reason for today's visit: _____

_____

_____

Have you ever had or been diagnosed with:

Anemia	☐ Yes ☐ No	Facial Weakness	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Balance disturbance	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No
Bleeding tendencies	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
Blood clots	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Blurred vision	☐ Yes ☐ No	Irregular pulse	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Difficulty with speech	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No

Cancer ☐ Yes ☐ No Type: _____

Kidney Disease ☐ Yes ☐ No Explain: _____

Liver Disease ☐ Yes ☐ No Explain: _____

Other: _____

Surgical History (please list all prior surgeries):

Date	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Patient Name: _____

Problems with anesthesia: ☐ Yes ☐ No

Are you claustrophobic: ☐ Yes ☐ No

Personal History:

Do you have children: ☐ Yes ☐ No If yes, how many: _____

Tobacco History:

☐ Current every day smoker # per day: _____ For how long: _____

☐ Current occasional smoker # per day: _____

☐ Former smoker When did you quit: _____

☐ Never smoked

Alcohol History:

☐ Consume alcohol daily How much per day: _____

☐ Consume alcohol socially How frequently: _____

☐ Never consume alcohol

Drug Use History:

Recreational drug use: ☐ Yes ☐ No

Allergies: ☐ Check here if you have no known allergies.

Latex allergy: ☐ Yes ☐ No

Iodine / Seafood allergy: ☐ Yes ☐ No

Medication(s) and reaction: _____

_____

Mammography:

If you are a woman (40 - 69 years of age), did you have a mammogram within the past year?

☐ Yes, approximate date: _____ ☐ No ☐ Unsure

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Patient Name: _____

Medications:

Please list all prescription medications, herbal supplements, and over the counter medications – use an additional sheet of paper if necessary.

Medication	Dose	Frequency

Family History:

		Relation	Type (if known)
Diabetes	☐ Yes ☐ No		
High Blood Pressure	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		
Strokes	☐ Yes ☐ No		
Brain Aneurysms	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

I have reviewed the information with the patient.

_____ _____

Signature of Individual Reviewing Form Date

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PATIENT PRIVACY FORM

Patient Name: _____ DOB: _____

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an "appointment reminder" is not classified as medical information.

Please indicate your communication preferences below:

☐ I give permission to leave medical information pertaining to me, my dependent or child, at the numbers listed below:

Contact Method	Yes / No	Phone Number
Home	☐ Yes ☐ No	
Answering Machine	☐ Yes ☐ No	
Work Phone	☐ Yes ☐ No	
Cell Phone	☐ Yes ☐ No	
Pager	☐ Yes ☐ No	

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.).

☐ Do not release medical information to anyone other than myself.

☐ I give permission to release medical information pertaining to me to the individual(s) listed below:

Name	Relationship	Phone Number

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____
Signature of Patient or Legal Representative Date

_____
Signer's Printed Name