



Patient Information and Authorization

Full Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Social Security Number: _____ - _____ - _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M D W

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Extension: _____

In an Emergency, notify: _____ Relationship: _____

Telephone: (____) _____ - _____ cell / home / work / other

- ◆ How did you learn about CardioScan? (please circle all that apply)
 Brochure Radio Television Newspaper Doctor Friend/Relative Health Fair
- ◆ Did a physician refer you? Y N Would like your results sent to this physician? Y N
 Physician's Full Name: _____ Telephone: (____) _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____
- ◆ Is there any other physician you would like us to correspond with? Y N
 Physician's Full Name: _____ Telephone: (____) _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____

--OR-- **DO NOT** release the results of my calcium-scoring exam to anyone other than me.

I hereby authorize Cardiovascular Consultants, P.C. to perform upon me a rapid CT scan of the coronary arteries. Furthermore, I understand that:

1. This is a limited CT scan of the chest for evaluation of coronary artery calcification only and is NOT intended for any other purpose.
2. This test does not reveal the percentage of blockage in the coronary arteries. Further cardiac testing would be required to determine that, if necessary.
3. During the course of the test, I will be exposed to radiation approximately equal to that received in a mammogram examination.
4. If I ever experience chest pain or shortness of breath, I should seek medical attention promptly, regardless of the results of this test.

 Patient Name Patient Signature Date