SOUTH ATLANTA RADIOLOGY ASSOCIATES

Have you had any procedures in this office before? No [ ] Yes [ ] When:_____

PATIENT:_____ SSN:_____
LAST FIRST MIDDLE

ADDRESS:_____APT:_____

CITY:_____ STATE:_____ ZIP:_____

EMAIL ADDRESS:_____

PHONE #:_____
DATE OF BIRTH:_____ SEX:___ MARITAL
STATUS_____
ALLERGIES:_____
MEDICATIONS:_____
DO YOU SMOKE:_____ If so, how long?_____
ETHNICITY: WHITE AFRICAN AMERICAN AMER. INDIAN
ASIAN HISPANIC OTHER:_____
LANGUAGE:_____ REFERRING PHYSICIAN:_____

NOTICE

IF YOU HAVE NO INSURANCE OR NO PROOF OF INSURANCE COVERAGE, PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE. THANK YOU.

INSURANCE:_____ POLICY #:_____
POLICY HOLDER:_____ RELATIONSHIP:_____
PHONE:_____ DOB:_____ SS#: _____
EMPLOYER NAME/PHONE:_____

I have reviewed a copy of south atlanta radiology associates (SARA) notice of privacy practices. I hereby authorize SARA to release any information in my examination to any insurance or physician(s) providing benefits, treatments or other policies in the course of my examination. I hereby with my signature assign and authorize my insurance carriers or provide physicians to make a payment directly to SARA for all my services rendered at this facility. I hereby with my signature understand that I am ultimately responsible for payment in full of services rendered in the event my insurance carrier or managed care plan denies payment in full or in part for any services rendered, including but not limited to all co-payments and/or deductions,non-covered services and supplies obtained during the course of care.

SIGNED: _____ DATE:_____

COVID-19 SCREENING QUESTIONAIRE

Patient temperature: _____

Are you currently experiencing or have you experienced in the past 14 days any of the following symptoms? (PLEASE CHECK ALL THAT APPLY)

1. FEVER **yes** ⏮ **no** ⏮
2. COUGH **yes** ⏮ **no** ⏮
3. SHORTNESS OF BREATH OR DIFFICULTY BREATHING **yes** ⏮ **no** ⏮
4. SORE THROAT **yes** ⏮ **no** ⏮
5. NEW LOSS OF TASTE OR SMELL **yes** ⏮ **no** ⏮
6. CHILLS **yes** ⏮ **no** ⏮
7. HEAD OR MUSCLE ACHES **yes** ⏮ **no** ⏮
8. NAUSEA/DIARRHEA/VOMITING **yes** ⏮ **no** ⏮

In the past 14 days, have you been in contact with anyone who has been experiencing the symptoms above? yes ⏮ **no** ⏮

In the past 14 days, have you been in contact with anyone that tested positive for COVID-19 ? yes ⏮ **no** ⏮

In the past 14 days, have you traveled outside of the United States? yes ⏮ **no** ⏮

Have you been tested for COVID-19? yes ⏮ **no** ⏮

What were your results? Positive ⏮ **or Negative** ⏮