QUEENS RADIOLOGY IMAGING PC

DIAGNOSTIC RADIOLOGY

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Patient

Name _____

DOB _____ Sex _____

Home Phone _____

Cell _____

Name of Insurance _____

Claim # _____

Referring Physician

Name _____

Fax # _____

Phone # _____

Address _____

Clinical Information _____

Signature _____ Date _____

☐ MRI

☐ Brain	☐ Shoulder	L R
☐ Chest	☐ Elbow	L R
☐ Abdomen	☐ Wrist	L R
☐ Pelvis	☐ Hand	L R
☐ TMJ	☐ Hip	L R
☐ C-Spine	☐ Knee	L R
☐ T-Spine	☐ Ankle	L R
☐ L-Spine	☐ Foot	L R

☐ Other _____

☐ CT

☐ Brain	☐ Shoulder	L R
☐ Chest	☐ Elbow	L R
☐ Abdomen	☐ Wrist	L R
☐ Pelvis	☐ Hand	L R
☐ TMJ	☐ Hip	L R
☐ C-Spine	☐ Knee	L R
☐ T-Spine	☐ Ankle	L R
☐ L-Spine	☐ Foot	L R

☐ Other _____

☐ X-Ray

☐ Chest (AP & Lat)	☐ Skull	
☐ Abd	☐ Hand	L R
☐ Cervical Spine	☐ Foot	L R
☐ Thoracic Spine	☐ Pelvis	
☐ Lumber	☐ Sacroiliac Joints	
☐ Ribs L R	☐ Hip	L R
☐ Shoulder L R	☐ Knee	L R
☐ Wrist L R	☐ Ankle	L R

☐ Other _____

☐ Musculoskeletal Ultrasoud

☐ Head & Neck/Soft Tissue
☐ Spinal Cord (Thoracic spine)
☐ Spinal cord (Lumbar spine)
☐ Pelvis L R
☐ Shoulder Joint L R
☐ Hand/Wrist joint L R
☐ Knee L R
☐ Ankle L R
☐ Other

Please Bring Proper Identification