PATIENT COVID-19 QUESTIONNAIRE

1) HAVE YOU TRAVELED OUTSIDE THE U.S. WITHIN THE LAST 21 DAYS? **YES OR NO**

2) HAVE YOU HAD A FEVER IN THE LAST 21 DAYS? **YES OR NO**

3) ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS? CHECK ALL THAT APPLY….

- **COUGH_____**
- **FEVER LASTED MORE THAN 24 HOURS ____**
- **DIFFICULTY BREATHING _____**
- **SORE THROAT _____**
- **FEELING SICK _____**
- **CHILLS _____**

4) HAVE YOU COME IN CONTACT WITH ANYONE WITH **CORONAVIRUS (COVID-19)**

WITHIN THE LAST 7 DAYS OR LESS **YES OR NO**

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

DEMOGRAPHIC FORM 2024

DATE _____

HAVE YOU BEEN SEEN AT THIS FACILITY? YES OR NO.

NAME _____ DATE OF BIRTH ____/_____/_____

SEX: (BORN AS) FEMALE OR MALE

_____ _____ _____

ADDRESS CITY, STATE ZIP CODE

_____ _____

PHONE NUMBER EMAIL ADDRESS

_____

GUARDIAN/PATIENT NAME (IF PATIENT A MINOR) RELATIONSHIP

_____ _____ _____

GUARDIAN/PATIENT SIGNATURE TO TREAT/SCAN DATE PHONE NUMBER

INSURANCE OR ATTORNEY INFORMATION

INSURANCE NAME	ATTORNEY NAME
POLICY NUMBER	CASE MANAGER/PARALEGAL NAME
PHONE	PHONE
EMPLOYER	FAX
PHONE	EMAIL
IS THIS ILLNESS WORKERC COMP YES OR NO	DATE OF INJURY

I give consent for **LEGACY OPEN MRI** to bill the above insurer and or attorney of record. I also consent to **LEGACY OPEN MRI** releasing personal identifiable information to these individuals/insurers for billing purposes. I understand this consent is valid for seven years or until all claims or audit findings are resolved. I understand that my consent is voluntary and that I may revoke my consent in writing at any time.

PATIENT PRINTED NAME	PATIENT SIGNATURE	DATE

RELEASE OF INFORMATION CONSENT 2024

___TODAY'S DATE_____

I authorize the following individual:

LEGACY OPEN MRI

101 EXECUTIVE CT SUITE 100A WAXAHACHIE TEXAS 75165

to release the confidential Medical Information which may include all BILLING, IMAGING REPORTS and or CD/FILMS to

PHYSCIAN NAME	**PHYSCIAN ADDRESS**	**PHYSCIAN TELEPHONE**
ATTORNEY NAME	**ATTORNEY ADDRESS**	**ATTORNEY TELEPHONE**

This form ☐ was read by me ☐ was read to me and I understand its meaning. All the blanks were filled in before the form was signed by me.

_____ _____

Signature Date

_____

Print Name

_____

Witness_____Date_____