

**North Fork Radiology, PC**

1333 Roanoke Avenue

Riverhead, NY 11901

**Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**What exam(s) are you having today?**

\_\_\_\_\_

In relation to the exam(s) that you are having today, **Please fully describe your symptoms** (in example: pain, swelling, tenderness, dizziness, headache, blurred vision, fever, cough, chills, etc.)

\_\_\_\_\_

**Please describe any medical problems or illnesses.**

\_\_\_\_\_

**Do you have any allergies? (If yes please describe.)**

\_\_\_\_\_

**Is the examination that you're having today a result of an automobile accident or a work related accident? (If so, please describe.)**

\_\_\_\_\_

**What physician requested the exam(s) you're having today?**

Name \_\_\_\_\_

**Please provide the following if readily available. You may leave blank if you're not certain.**

Physician

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Do you want a copy of your medical report sent to another physician? (If yes please complete.)**

Name \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_