

Nuclear Medicine Associates  
1950 Court Street  
Redding, CA 96001  
(530) 225-8008

ID# \_\_\_\_\_

EXAM \_\_\_\_\_ # \_\_\_\_\_

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ M/ F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Last name, First name

Parent or Guardian: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security#: \_\_\_\_\_

Whom may we contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**Female patients only: -are you now, or could you possibly be pregnant? Yes/ No**

Referring Physician: \_\_\_\_\_

Additional copies \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DO NOT WRITE BELOW LINE**

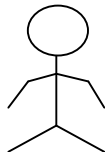
Comments: \_\_\_\_\_

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ICD-9: \_\_\_\_\_

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INJ. SITE INITIAL: \_\_\_\_\_

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