



X-RAY

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax#:
Clinical History:		
Is the patient pregnant? YES NO		
Physician Signature:		Date:

X-RAY

<p>CHEST</p> <p><input type="checkbox"/> Chest PA &LAT</p> <p><input type="checkbox"/> Chest PA Only</p> <p><input type="checkbox"/> Chest Oblique</p> <p><input type="checkbox"/> Apical Lordotic</p> <p><input type="checkbox"/> Decubitis</p> <p>ABDOMEN</p> <p><input type="checkbox"/> Abdomen (Flat Plate)</p> <p><input type="checkbox"/> Flat & Upright</p> <p><input type="checkbox"/> KUB</p> <p><input type="checkbox"/> Bone Age</p> <p><input type="checkbox"/> Bone Survey</p> <p>OTHER: _____</p>	<p>NEURO & ENT</p> <p><input type="checkbox"/> Skull</p> <p><input type="checkbox"/> Orbit</p> <p><input type="checkbox"/> Paranasal Sinus</p> <p><input type="checkbox"/> Mandible</p> <p><input type="checkbox"/> TMJ's</p> <p><input type="checkbox"/> Nasal Bones</p> <p><input type="checkbox"/> Soft Tissue Neck</p> <p>SPINE</p> <p><input type="checkbox"/> Cervical</p> <p><input type="checkbox"/> Thoracic</p> <p><input type="checkbox"/> Lumbar</p> <p><input type="checkbox"/> Sacrum</p> <p><input type="checkbox"/> Coccyx</p>	<p>BONES</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Femur</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Knee</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Tib/Fib</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Ankle</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Clavicle</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Scapula</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Humerus</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Elbow</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Forearm</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Wrist</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Ribs</td><td><input type="checkbox"/> R</td><td><input type="checkbox"/> L</td></tr> <tr><td><input type="checkbox"/> Sternum</td><td></td><td></td></tr> </table>	<input type="checkbox"/> Hip	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Femur	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Knee	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Tib/Fib	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Ankle	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Foot	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Clavicle	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Scapula	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Humerus	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Elbow	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Forearm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Wrist	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Hand	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Ribs	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Sternum		
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No Appointment Necessary. Walk-In Hours:
 Monday - Thursday 8am – 8pm / Friday 8am – 5pm / Saturday 8am – 1pm
 Please have your insurance card available. **Please Note:** Co payments are collected at time of visit.