

PLEASE READ AND SIGN

DATE OF SERVICE:

REFERRING PHYSICIAN/PHONE NUMBER:

PATIENT NAME:

SOCIAL SECURITY #:

Account Number:

DOB:

AGE:

**IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY**

I hereby consent to and authorize Eastside Diagnostic Imaging, PLLC, its doctors, technicians and medical personnel to perform a

\_\_\_\_\_ write in type of exam

\_\_\_\_\_ Date

I have completed the patient questionnaire and provided all the information with regard to my medical history.

The nature and purpose of this procedure have been explained to me. I understand that there will be a needle inserted into my body.

The risks of injury, infection, bleeding and other complications, despite all precaution have been explained to me. All questions that I may have in reference to this procedure and its associated risks have been explained to my satisfaction.

\_\_\_\_\_  
Signature of Patient or Guardian  
or person authorized to consent for this patient

\_\_\_\_\_ Date

If for any reason following this procedure you experience discomfort or other symptoms, please call our office at 212-888-1000 ext 1512 or call your referring physician.

**For office use only:**

\_\_\_\_\_  
**Signature of Radiologist**

\_\_\_\_\_ Date

\_\_\_\_\_  
**Signature of Technologist**

\_\_\_\_\_ Date