PET/CT Imaging Center
of Northwest Florida

PATIENT INFORMATION SHEET

Patient Name: _____ Date: _____
Last First

Date of birth: _____ Social Security Number: _____- _____-_____

Phone #: Cell_____Other_____

Email address: _____

Address: _____ Apt./Lot: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance: _____

Secondary Insurance: _____

Name & DOB of policyholder (if different from patient): _____

Emergency Contact: _____ Phone #: _____

Have you eaten or had anything to drink besides water today?	YES	NO
Are you currently taking any diabetic medications and/or insulin?	YES	NO
Have you been diagnosed with cancer?	YES	NO
Are you pregnant and/or breastfeeding?	YES	NO
Have you been diagnosed with HIV, AIDS or Hepatitis?	YES	NO

Are you claustrophobic? YES NO