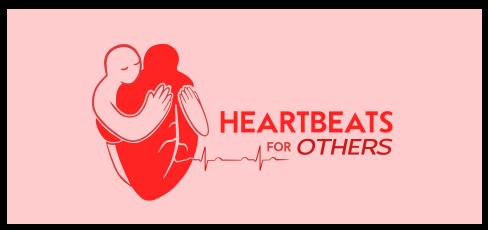

Registration Form

Organization:

Patient Information:

First Name Last Name

Gender ◯ Male ◯ Female

Date Birth

Cell Phone Email

Address

City State Zip

Insurer Information:

First Name Last Name

Gender ◯ Male ◯ Female

Date Birth

Cell Phone Email

Address

City State Zip

Insurance Information:

Insurance Company

Address

City State Zip

Insurance Phone Group

Policy/Claim#

Medical History

Patient History (check all that apply)

☐ High blood pressure	☐ Diabetes	☐ High Cholesterol
☐ Heart catheterization	☐ Congestive heart failure	☐ Angioplasty
☐ Heart attack	☐ Stroke	☐ Asthma
☐ Valve problem	☐ Heart murmur	☐ Rheumatic fever
☐ Loss of consciousness	☐ Emphysema	☐ Pneumonia

☐ Arrhythmia (irregular heart beat)	☐ Anemia	☐ Ulcer
☐ Vascular (blood vessel) disease	☐ Bleeding tendency	☐ Arthritis
☐ Liver disease / hepatitis	☐ Kidney disease	☐ Glaucoma
☐ Migraine headaches	☐ Thyroid disease	

Family medical history (check all that apply)

☐ High blood pressure	☐ Sudden death of patient (under 50)
☐ Diabetes	☐ Congestive heart failure
☐ High cholesterol	☐ Arrhythmia (irregular heart beat)
☐ Heart attack	☐ Vascular (blood vessel) disease
☐ Angioplasty	☐ Cancer
☐ Coronary bypass surgery	☐ Stroke

Current symptoms (check all that apply)

General:

- ☐ Decreased appetite
- ☐ Fever
- ☐ Chills
- ☐ Weight change (loss or gain)
- ☐ Night Sweats
- ☐ Fatigue

ENT:

- ☐ Headache
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Double vision
- ☐ Blurred vision
- ☐ Ringing in ears

Hearing loss
Hoarseness
Nosebleeds

Respiratory:

- ☐ Persistent cough
- ☐ Shortness of breath with rest
- ☐ Shortness of breath with activity
- ☐ Snoring
- ☐ Coughing blood
- ☐ Wheezing

Hematological:

- ☐ Bleed easily
- ☐ Bruise easily

Genitourinary:

- ☐ Blood in urine

Cardiovascular:

- ☐ Chest pain, pressure , or tightness
- ☐ Passing out
- ☐ Heart palpitations
- ☐ Irregular heart beat
- ☐ Non-healing sores on legs or feet
- ☐ Pain in legs or hips with walking
- ☐ Shortness of breath when lying flat
- ☐ Swelling of feet or ankles
- ☐ Waking up panicky and short of breath
- ☐ Dizziness

Gastrointestinal:

- ☐ Nausea and vomiting
- ☐ Nausea without vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn/ indigestion
- ☐ Rectal bleeding
- ☐ Black or bloody stool
- ☐ Difficulty swallowing

Endocrine:

- ☐ Excessive thirst
- ☐ Increased urination
- ☐ Hair loss

Neurological:

- ☐ Headaches
- ☐ Numbness / tingling on one side
- ☐ Weakness on one side
- ☐ Difficulty speaking

☐ Pain with urination ☐ Frequent urination	☐ Loss of memory

Height: Weight:

Sport/activity (primary):

Additional sports:

Allergies

Do you have allergies to drugs, food, seafood, latex, dye, grass, etc.?

List allergies:	Identify related reaction risk (shortness of breath, rash, hives, itching, other):

Current medications:

List all vitamins, prescriptions medications, and over the counter medications.

Patient disclosure, consent and release:

Sono Millions Imaging have agreed to provide students/athletes with a cardiac diagnostic testing to include EKG, echocardiogram and vascular studies. The purpose of this examination to test for conditions that could cause sudden cardiac death. This form is meant to (1) inform you about the screening, (2) to document your consent to the testing, and (3) to inform you of certain limitations on any claims that you might bring arising out of the testing. This form informs you of the importance of taking personal responsibility for your child's or your own health needs and asks for a personal commitment from you to obtain appropriate follow-up care and treatment in the event the testing detects an abnormality.

Consent for cardiac diagnostic testing:

I consent to have the associates, technologists, technical assistants, cardiologists, and other supporting healthcare providers affiliated with Sono Millions Imaging to perform, interpret, and communicate the information and results of a limited cardiovascular testing procedure (The "Procedure") on myself, my child, or a dependent. I understand the Procedure is performed only to help identify people who could be at risk for sudden cardiac death, and the Procedure alone is not sufficient to confirm or rule out a diagnosis of HCM or any other medical condition, and that additional procedures and testing may need to be performed in the event the results of the Procedure indicates an "abnormal" finding. I have accurately completed a medical health

history questionnaire.

Communication of results:
I understand that Sono Millions Imaging will communicate the results of testing (verbal or written) to the school administrator. Additionally, the communication of abnormal results will be made available to the parents/guardian/insurance policy holder. Copies of all results can be arranged for pickup from the school administrator.

Contact information to be used by cardiologist in the event of a significant/abnormal finding.

Name Relationship to patient

Cell phone Secondary phone

Personal commitment to follow-up results:
I recognize and acknowledge that I am personally responsible for seeking any additional medical care of testing following completion of the procedure, and in the event that this Procedure suggests there is an abnormality in the heart, I understand and acknowledge that is my responsibility to seek advice and if medically indicated, further testing and treatment from a physician of my choice. I understand that follow-up care and treatment is not a part of the program and I am financially responsible for the cost of any and all of the follow-up care, treatment and/or procedures whether or not covered by my insurance.

Billing of Insurance:
I understand that any and all available insurance will be provided to Sono Millions Imaging and its affiliates for the purpose of billing

Acknowledgement:
I certify that I have read the form or have had it read to me, that the blank spaces have been filled in and I understand thee contents.

Signature:

Email:

.