



361 Woodruff Rd.  
 Greenville, SC 29607  
 Phone: 864-775-5004  
 Fax: 864-775-5012

APPOINTMENT DATE ____/____/____ _____ AM / PM
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## AMERICAN HEALTH IMAGING OF GREENVILLE

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_  Call patient to schedule appointment

Insurance Name/ ID #: \_\_\_\_\_ Auth#: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

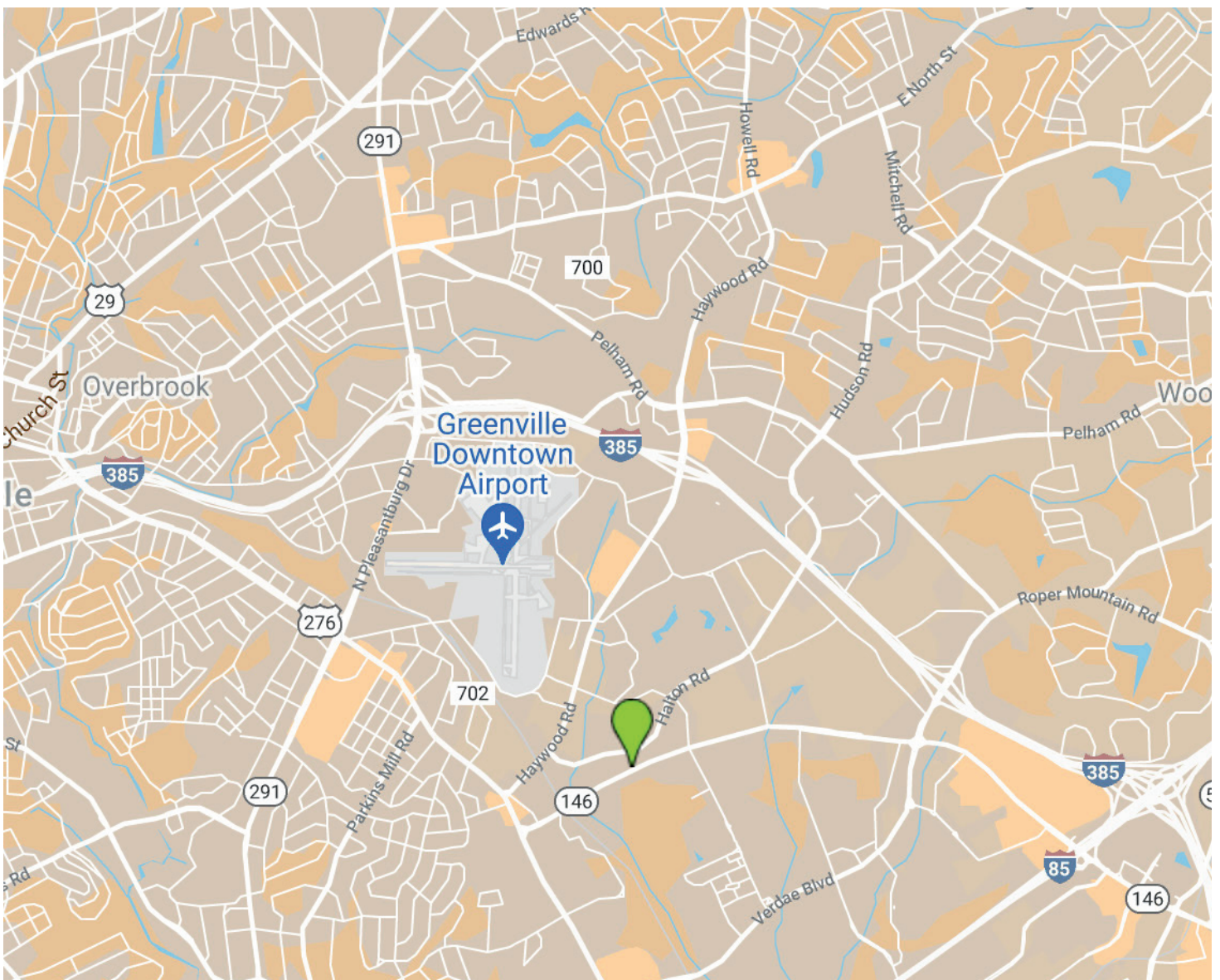
<input type="checkbox"/> CD <input type="checkbox"/> Report Only <input type="checkbox"/> STAT <input type="checkbox"/> CALL REPORT TO: _____	Creatinine: ____ GFR: ____ Date Drawn: _____ Appt. Date: _____ Appt. Time: _____ AM / PM
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Open MRI	ULTRASOUND
<input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine/Dorsal <input type="checkbox"/> L-Spine <input type="checkbox"/> Flexion Extension <input type="checkbox"/> Weight-Bearing (Orthostatic) <input type="checkbox"/> Lie-Down (Supine)  <input type="checkbox"/> Shoulder L R <input type="checkbox"/> Hip L R <input type="checkbox"/> Hindfoot L R <input type="checkbox"/> Elbow L R <input type="checkbox"/> Knee L R <input type="checkbox"/> Other _____ <input type="checkbox"/> Wrist L R <input type="checkbox"/> Ankle L R <input type="checkbox"/> Hand L R <input type="checkbox"/> Forefoot L R	<input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Thyroid <input type="checkbox"/> Extremity Non-Vascular <input type="checkbox"/> Retroperitoneal Renal <input type="checkbox"/> Scrotum <input type="checkbox"/> Carotid Bilateral <input type="checkbox"/> Lower Extremity Venous, Bilateral <input type="checkbox"/> Lower Extremity Venous, Unilateral L R <input type="checkbox"/> Upper Extremity Venous, Bilateral <input type="checkbox"/> Upper Extremity Venous, Unilateral L R  <input type="checkbox"/> Transvaginal <input type="checkbox"/> Renal/Bladder <input type="checkbox"/> Pelvic, Non-OB limited <input type="checkbox"/> Renal with Doppler <input type="checkbox"/> Transabdominal, transvaginal <input type="checkbox"/> Limited Liver with Doppler

ATTORNEY	X-RAY
ICD-10 Code / Diagnosis: _____  Attorney Name: _____  Attorney Number: _____  Date of Injury: _____  <input type="checkbox"/> Work Comp <input type="checkbox"/> MVA <input type="checkbox"/> Slip & Fall	Please Indicate: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Spine _____ Flex/Ext <input type="checkbox"/> Nasal <input type="checkbox"/> Sinuses <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Pelvis <input type="checkbox"/> Skull <input type="checkbox"/> Cervical <input type="checkbox"/> Facial Bones <input type="checkbox"/> Hand <input type="checkbox"/> Thoracic <input type="checkbox"/> Foot <input type="checkbox"/> Lumbar <input type="checkbox"/> Ribs <input type="checkbox"/> Extremity and Joints <input type="checkbox"/> Other: _____

Physician Signature: _____	Date: _____
Physician Name: _____ Physician Phone: _____ Physician Fax: _____	

FREE PARKING • SAME DAY APPOINTMENTS • NEXT DAY RESULTS



## STATE-OF-THE-ART DIAGNOSTIC IMAGING NOW AVAILABLE IN GREENVILLE

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