The LiverLAB
Fibroscan Clinic

Patient Registration Form

Patient Name: (Last) (First) (M.I.)
_____

Date Of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Status: Single _____ Married _____ Other: _____

Referring Physician: _____

Health Insurance:_____

Is this your first LiverLab Fibroscan? No ___ Yes ___
If no, approx. date of 1st fibroscan? _____

In Case of Emergency

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

Medical History

Please mark if you have had any of these conditions:

Non-Alcoholic Fatty Liver Disease (NAFLD) _____
Non-Alcoholic SteatoHepatitis (NASH) _____
Alcoholic Liver Disease (ALD) _____
Hepatitis C _____
Diabetes _____
Autoimmune Hepatitis _____
Bile Duct Disease _____
Ascites _____
Hepatitis B _____

Do you have any Implantable Electronic Devices? _____
Are you pregnant? Yes_____ No_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to The LiverLab. I understand that I am financially responsible for any balance. I also authorize The LiverLab or insurance company to release any information required to process my claims.

Patient signature: _____Date: _____

Guardian: _____