

**PATIENT INFORMATION**

|   |                 |                |  |
|---|-----------------|----------------|--|
| NAME: LAST, FIRST MI  | SOC SEC NUMBER: | DATE OF BIRTH: | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| ADDRESS:  | Home Phone:     |                |  |
|   | Work Phone:     |                |  |
| CITY/STATE/ZIP:   | Cell Phone:     |                |  |
| Employer:   | EMAIL:          |                |  |
| Preferred Notification Method (select one): <input type="checkbox"/> EMAIL <input type="checkbox"/> MAIL <input type="checkbox"/> CALL HOME <input type="checkbox"/> CALL CELL <input type="checkbox"/> CALL WORK |                 |                |  |
| Guarantor/Individual Responsible for Bill:  |                 |                |  |

**INSURANCE INFORMATION**

| PRIMARY INSURANCE  |  | SECONDARY INSURANCE   |  |
|--|--|---|--|
| Insurance Name:  |  | Insurance Name:   |  |
| ID#  | GROUP#   | ID#   | GROUP#   |
| Policy Holder Name (If different from Patient):<br>Self <input type="checkbox"/> |  | Policy Holder Name(if different from Patient):<br>Self <input type="checkbox"/> |  |
| Policy Holder Address(If different from Patient):                                |  | Policy Holder Address(If different from Patient):                               |  |
|  |  |   |  |
| Date of Birth:   | Sex: M <input type="checkbox"/> F <input type="checkbox"/> | Date of Birth:  | Sex: M <input type="checkbox"/> F <input type="checkbox"/> |
| Relationship to Patient:   | Phone #  | Relationship to Patient:  | Phone #  |

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Is this a Worker's Compensation Claim? Yes \_\_\_ No \_\_\_ . If yes, Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Is this a Motor Vehicle Claim? Yes \_\_\_ No \_\_\_ . If yes, Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**PAYMENT POLICY**

**It is our payment policy to collect the appropriate payment due from the patient at the time of service is rendered. This may only be your co-payment, co-insurance and/or deductible according to your health insurance company benefit plan, but we do ask for payment at the time of your visit.**

1. If you are a Medicare recipient, we will file your Medicare claim as required for our participation in the Medicare program. Medicare normally forwards claims to your secondary (supplementary) insurance, if any, for processing of co-insurance or deductibles. This does not guarantee your secondary insurance will pay these balances.
2. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to verify your insurance benefits; however, you are responsible for knowing the benefits/coverage of your insurance.

**Initial:** \_\_\_\_\_

Please complete the back of this page.



# MRI QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

PHYSICIANS TO RECEIVE REPORTS: \_\_\_\_\_

REASON FOR EXAM \_\_\_\_\_

SURGICAL/MEDICAL HISTORY \_\_\_\_\_

HAVE YOU EVER HAD TRAUMA TO THE AREA BEING IMAGED?  YES  NO

DATE OF INJURY/ILLNESS \_\_\_\_\_

HAVE YOU HAD SURGERY ON THE BODY PART BEING IMAGED TODAY?   YES  NO

PREVIOUS DIAGNOSTIC EXAM (relating to today's study) \_\_\_\_\_

WHERE? \_\_\_\_\_

ALLERGIES \_\_\_\_\_ WEIGHT \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

- Do you have cochlear (ear) implants, hearing aid, or dentures  YES  NO
- Do you have a cardiac pacemaker or lead wires?  YES  NO
- Do you have aneurysm clips  YES  NO
- Are you pregnant?  YES  NO
- Are you breastfeeding?  YES  NO
- Do you have surgical implants?  YES  NO
- Do you have a cardiac defibrillator implant?  YES  NO
- Do you have any metallic electronic implants or devices?  YES  NO
- Do you have any type of prosthesis, implant or artificial limb  YES  NO
- Do you have a penile implant?  YES  NO
- Do you have an artificial eye?  YES  NO
- Do you have a heart valve prosthesis, stent, filter or coil?  YES  NO
- Do you have a shunt?  YES  NO
- Do you have any vascular access ports or catheter  YES  NO
- Do you have any magnetically activated implants or devices  YES  NO
- Do you have a neuro-stimulation system or tens pack?  YES  NO
- Have you ever gotten metal in your eyes or skin?  YES  NO
- Do you have an IUD, diaphragm or pessary ring?  YES  NO
- Do you have Diabetes?  YES  NO
- Do you have an insulin or drug infusion device?  YES  NO
- Do you have any medication patches  YES  NO
- Do you have any tattoos, permanent makeup, or body piercing?  YES  NO
- Do you have Sickle Cell or Hemolytic anemia?  YES  NO
- Do you have kidney disease?  YES  NO
- Are you on dialysis?  YES  NO
- Do you have, or ever had cancer?  YES  NO

If you answered YES to any questions, please explain:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Technologist Signature Date