PATIENT PROFILE

PATIENT INFORMATION

Name:_____ Patient ID#:_____ Sex: [ ]M [ ]F

Address:_____ Date of Birth:_____

City:_____ State:_____ Zip:_____ Social Security #:_____

Home Phone:_____ Marital Status: [ ] Married [ ] Single

Work Phone:_____ Referring Physician:_____

Cell Phone:_____ Primary Care Physician:_____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] not Employed

Employer:_____

Phone:_____

EMERGENCY CONTACTS (NAME & PHONE)

(1)_____

(2)_____

(3)_____

RESPONSIBLE PARTY (Must complete if responsible party is other than insured or patient)

[ ] Same as Patient [ ] Same as Insured Relationship to Patient:_____

Name:_____ Employer:_____

Address:_____ Phone:_____

City, State & Zip:_____ Date of Birth:_____

Social Security:_____

RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize The Woodlands Open MRI & Imaging Center to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission. _____ (initials)

ASSIGNMENT OF BENEFITS

In consideration for the services rendered, I hereby irrevocably assign and transfer to The Woodlands Open MRI & Imaging Center, and to any physician providing services, all rights, title and interest, to the benefits payable by any and all third party payors that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow The Woodlands Open MRI & Imaging Center, or those physicians, to pursue any such right of recovery. **Even though I have made this assignment, I understand that The Woodlands Open MRI & Imaging Center, has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payors, and I am responsible for payment for any charges not paid for me on my behalf.**

_____ (initials)

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance; therefore, making me fully responsible for any charges incurred.

Patient/Responsible Party Signature: _____

THE WOODLANDS
OPEN MRI & IMAGING CENTER

MRI QUESTIONNAIRE

Name _____ DOB _____ Age _____
Sex M ___ F ___ Weight _____ Referring Physician _____
Please list reason for the MRI and details of your symptoms _____
_____
_____
Duration of symptoms _____ Date of onset of symptoms or injury _____
Are your symptoms the result of an injury? _____ If so, please describe _____
Work related injury? _____ Or MVA? _____
Please list all prior surgeries _____
Are you claustrophobic YES _____ NO _____ Any other MRI related problems _____
Have you ever had a reaction to MRI contrast? _____ If so, please identify _____
Please list any prior related diagnostic examinations and date _____

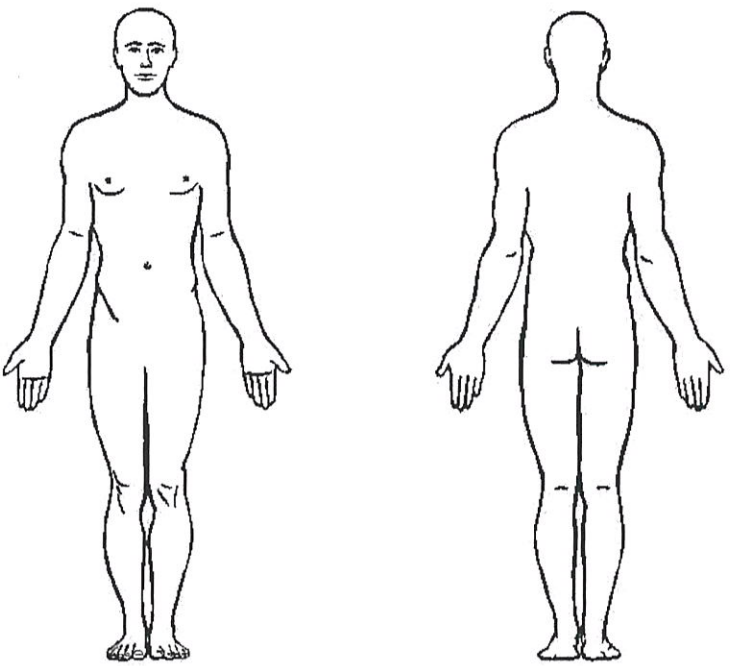
Please indicate if you have any of the following:

Yes	No	
O	O	Cardiac Pacemaker, wires, or defibrillator
O	O	Brain Aneurysm clips
O	O	Vascular stents, filters, coils or artificial heart valves
O	O	Implanted drug infusion pump or insulin pump
O	O	Implanted neurostimulator, spinal cord or bone stimulator
O	O	Work with metal or had metal removed from your eyes
O	O	Hearing aid, cochlear or other ear implant
O	O	Eye implant, eyelid spring, retinal tack, or artificial eye
O	O	Metal shrapnel, bullet, BBs, or pellets
O	O	Electronic or magnetically-activated implant or device
O	O	Any type of prosthesis or orthopedic implant
O	O	Magnetic dental implant
O	O	Body piercing jewelry
O	O	Tattoos or permanent make-up
O	O	Are you pregnant or breast feeding?
O	O	Penile implants
O	O	History of Cancer? If so, what type? _____

For patients having contrast study:

Yes	No	
O	O	Are you allergic to MR contrast (Gadolinium)
O	O	Are you diabetic? If yes, list medication _____
		_____
O	O	Kidney problems
O	O	Hypertension
O	O	Are you 60 years old or over?

Please shade in the areas where you are having pain or symptoms



I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and the MRI procedure that I am about to undergo.
Patient's Signature _____ Today's Date _____

Signature of Person Completing Form _____ Relationship _____

Form Information Reviewed By: _____ _____
Front Desk Technologist