

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: _____

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 _____

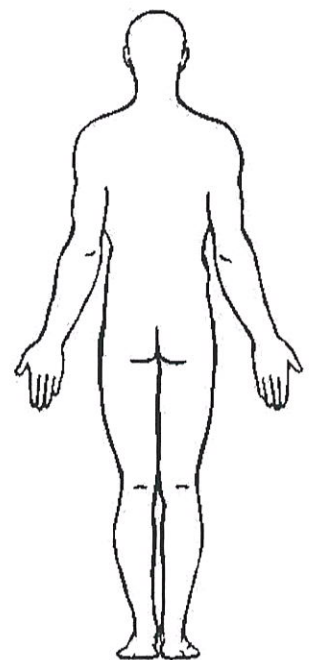
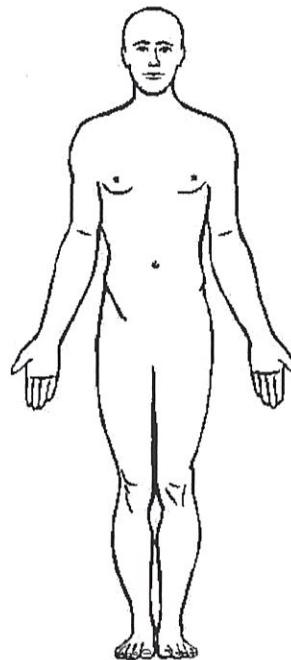
Please list any prior related diagnostic examinations and date _____

Please indicate if you have any of the following:

Yes No

- Cardiac Pacemaker, wires, or defibrillator
- Brain Aneurysm clips
- Vascular stents, filters, coils or artificial heart valves
- Implanted drug infusion pump or insulin pump
- Implanted neurostimulator, spinal cord or bone stimulator
- Work with metal or had metal removed from your eyes
- Hearing aid, cochlear or other ear implant
- Eye implant, eyelid spring, retinal tack, or artificial eye
- Metal shrapnel, bullet, BBs, or pellets
- Electronic or magnetically-activated implant or device
- Any type of prosthesis or orthopedic implant
- Magnetic dental implant
- Body piercing jewelry
- Tattoos or permanent make-up
- Are you pregnant or breast feeding?
- Penile implants
- History of Cancer? If so, what type? _____

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



For patients having contrast study:

Yes No

- Are you allergic to MR contrast (Gadolinium)
- Are you diabetic? If yes, list medication _____
- Kidney problems
- Hypertension
- Are you 60 years old or over?

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