

PATIENT REGISTRATION

Name _____ Social Security # _____ - _____ - _____

Last _____ **First** _____ **Middle** _____
 Address _____ Birth Date: _____ Cell phone () _____ Age _____

City _____ St _____ Zip _____ Sex: M F Date of Injury _____

Phone () _____ - _____ Referred by: _____

Accident? Yes No / Auto Work Other Employment Status: Employed Student (F/T-P/T) _____

Employer _____ Occupation _____ Work Phone () _____ - _____

Nearest Relative/Friend Not Living with You _____ Phone () _____ - _____

Spouse Name _____ Spouse Employed by: _____ Phone () _____ - _____

Insurance Information

Medical Ins. Co. #1

Social Sec. # _____
 Of Insured _____ - _____ - _____ Policy# or Group# _____ Relationship to patient _____

Insured's Name _____ Authorization: _____

DOB of Insured _____ Employer _____ Insurance Name _____

Address _____ City _____ St _____ Zip _____ Phone () _____ - _____

Medical Ins. Co. #2

Social Sec. # _____
 Of Insured _____ - _____ - _____ Policy# or Group# _____ Relationship to patient _____

Insured's Name _____ Authorization: _____

DOB of Insured _____ Employer _____ Insurance Name _____

Address _____ City _____ St _____ Zip _____ Phone () _____ - _____

Attorney? Yes No Attorney Name: _____ Phone () _____ - _____

Auto/Work Comp Ins. (Name/Address) _____

Adjuster Name _____ Phone () _____ - _____

I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING MEDICAL GROUP, INC** I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature _____ Date _____

MRI PRE-PROCEDURE SCREENING FORM

Name _____ Height _____ Weight _____

Birth Date _____ Male Female M.I. _____ Today's Date _____

Physician's name & address _____

Briefly describe why you are having this MRI scan (clinical history) _____

1. Have you ever had surgery or any other invasive procedures? Yes No

If yes, please list with approximate date of the procedure:

2. Have you had any previous studies? Yes No If yes, please list below.

	<u>Body Part</u>	<u>Date</u>	<u>Facility Location</u>
MRI:	_____	/ /	_____
CT/Computed Tomography:	_____	/ /	_____
X-Ray:	_____	/ /	_____
Ultrasound:	_____	/ /	_____
Nuclear Medicine:	_____	/ /	_____

3. Have you ever:

- worked as a machinist, metal worker, or in any profession or hobby grinding metal?
- had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, or foreign body)?
- been injured by a metallic foreign body (e.g., bullet, BB, buckshot, or shrapnel)?

Yes No If yes, please describe: _____

4. Are you pregnant, experiencing a late menstrual period, or having fertility treatments? Yes No

5. Are you breast feeding? Yes No 6. Date of last menstrual period: _____ / _____ / _____

7. Are you taking oral contraceptives or receiving hormone treatment? Yes No

8. Are you currently taking or have recently taken any medication? Yes No

If yes, please list: _____

9. Do you have medication allergies or other allergies? Yes No If yes, please list: _____

10. Do you have anemia, diseases affecting your blood, history of kidney disease or seizures? Yes No

If yes, please describe: _____

11. Have you ever had asthma, an allergic reaction, respiratory disease, or a reaction to a contrast medium used for an MRI or CT exam? Yes No

If yes, please describe: _____