Registration Form

<table>
<tr><td colspan="2">Patient Name First MI Last</td><td colspan="2">Date of Birth</td><td>Age</td></tr>
<tr><td>Home Address Apt #</td><td>City</td><td>State</td><td colspan="2">Zipcode</td></tr>
<tr><td>Social Security #</td><td>Sex
M F</td><td colspan="3">Home Phone</td></tr>
<tr><td colspan="2">Employer Name</td><td colspan="3">Work Phone</td></tr>
<tr><td>Referred by Dr.</td><td>Date of Injury/Illness</td><td colspan="3">Cell Phone</td></tr>
<tr><td>If Work Comp Related, Employer Where Injury Occurred</td><td>Auto Accident
Related? Y N</td><td colspan="3">Restrictions when leaving message/voicemail:
YES:</td></tr>
<tr><td colspan="5">Assignment of Insurance Benefits: I hereby authorize payment directly to the Center listed above. In the event payments are made directly to me, I agree to remit such payment to the Center. Should my Insurance Company or Attorney refuse to honor the bill, I agree to be responsible for the balance. I further agree to be responsible for said debt and any collection fees or Attorney fees involved in the collection of this debt.
Patient Signature: Date:</td></tr>
<tr><td colspan="5">Release of Information: This authorization or photo copy hereof will authorize the release of the requested medical records/reports and or any other records when necessary to Government Agencies, Insurance Carriers, and Review Agencies responsible for pre-certification and payment for services rendered. I further authorize release of such medical records associated for the performance of services requested by me or on my behalf.
Patient Signature: Date:</td></tr>
<tr><td colspan="5">Duplicate Film Charge: One set of film will be provided with your procedure. For any request for extra film, there will be a charge of $25 per sheet or $30 for a CD.
Initial ____________________</td></tr>
</table>

Acknowledgment Receipt of Notice of Privacy Practices

I, ____ understand that under HIPAA regulations, I have the right to request and receive a paper copy of the Notice of Privacy Practices.

* Even if I have agreed to receive this notice electronically, I am still entitled to a paper copy.
* I understand I am entitled to receive a paper copy and have chosen not to take it.
* If signature is not obtained, please explain why: ____

Signature of Patient ____________________ Date ____________________

UNIVERSITY MEDICAL IMAGING
MRI Patient Intake Questionnaire

Patient Name: ______________________________ Weight: __________ DOB: ______________

1. What is the reason or health problem that your physician ordered this exam for you?

____

2. What are your symptoms related to your exam today?

____

3. If spine injury, check if any apply to you:

	Left Arm	Right Arm	Left Leg	Right Leg
Pain				
Numbness				

4. What was your date of injury and/or onset of symptoms? ______________________

5. Have you had a previous MRI or other type of diagnostic exam of the area we are imaging today? Yes No

6. If yes, where and when? ____

MRI SAFETY QUESTIONNAIRE

MRI Procedures are non-invasive and generally safe, however if any of the following exist, special preparations may be required. Please check Yes or No to indicate if you have had any of the following:

Y	N	
		Brain Aneurysm Clips
		Cardiac Pacemaker/ Cardiac Defibrillator
		Implanted Pain Pump/ Insulin Pump
		Tens Unit or Neurostimulator
		Hearing Aids or Coclear Implant (Ear Implants)
		Vascular Clips or Clamps
		Stents (Cardiac or other)
		Dentures/ Dental Implants/ Braces/ Retainers
		Eye Implants/ Eye Surgery
		Surgically Metallic Implants
		Brain Surgery
		Prosthesis Implant or Limb
		Surgery to the area being imaged today?
		Are you known to be claustrophobic (uneasiness in small areas)?
		Have you ever worked with metal, such as cutting, welding or used a grinder in the past?
		If YES, did or could you have METAL FRAGMENTS lodged in your eyes?

Y	N	
		Body Piercing
		Permanent Eyeliner or Makeup
		Tattoos or Recent Tattoos
		Shrapnel/ Metal Fragments/ Bullets
		Diabetes
		Kidney Disease
		Kidney or Liver Transplant
		History of Cancer
		IUD/ or Diaphragms (Female)
		Could you be Pregnant?
		Are you Nursing?
		Allergies to Medication/ Latex
		Currently wear a Nicotine/other Drug Patch?

Patient Signature: ______________________________ Date: ______________

TECHNICIAN USE ONLY: ______________________________ TECH INITIALS: ____________

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