

Jacket # _____

Study Ordered: _____

Open Air MRI of Miss-Lou Patient Information Sheet

Patient Name: _____ Date: _____

Mailing Address: _____
(Number) (City) (State) (Zip)

Phone: (____) _____ Social Sec. #: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Work #: (____) _____

.....
Guarantor/Insured Information

Name: _____ Relationship to Patient: _____ DOB _____

Address (if different): _____
(Number) (City) (State) (Zip)

Home #: _____ Employer: _____ Work #: _____
.....

Please describe your pain, injury, or discomfort in detail: _____

How long have you been experiencing these symptoms: _____

Circle symptoms if any:

Headaches	Seizures	Weakness	Confusion
Hearing Changes	Visual Changes	Loss of Balance	Dizziness
Speech Difficulties	Difficulty Walking	Pain/Numbness	Memory Loss

Where are the above symptoms located if applicable: _____

Please check any previous exams relating to this injury: _____ MRI _____ CT Scan _____ X-Rays

If yes, where (Name of facility and date): _____

Are you claustrophobic: YES/NO

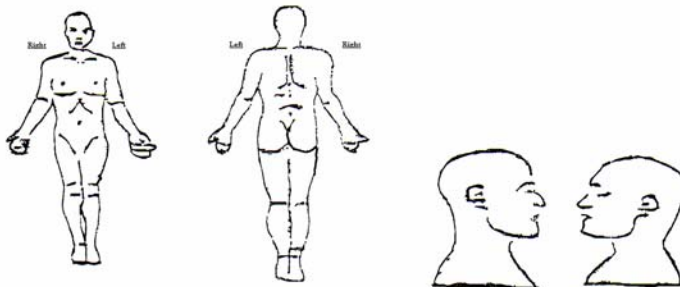
Please circle yes or no to each statement:

Aneurysm Clips	Yes/No	Prosthesis	Yes/No	Previous Surgeries	Yes/No
Pacemaker	Yes/No	Ear Implants	Yes/No	Sickle Cell Anemia	Yes/No
Pregnant	Yes/No	Heart Valves	Yes/No	History of Cancer	Yes/No
Metal in Eyes	Yes/No	Liver Disease	Yes/No	Metallic Implants	Yes/No
Dentures	Yes/No	IUD/Diaphragm	Yes/No	Head/Neck Surgery	Yes/No
Anxious	Yes/No	Previous CT Scan	Yes/No	Diabetes	Yes/No
Surgical Metal	Yes/No	Previous MRI	Yes/No	Shrapnel	Yes/No
Drug Allergies	Yes/No	Hearing Aids	Yes/No	High Blood Pressure	Yes/No
Blood Disorder	Yes/No	Breast Feeding	Yes/No	Bowel Problems	Yes/No
Gun Shot Wound	Yes/No	Bladder Problems	Yes/No	Previous Myelogram	Yes/No

If you have answered YES to any of the statements on the previous page, please describe in detail, also when occurred:

Additional History:

Draw on figure where pain or symptoms are located:



If you have any questions feel free to ask the Technologist performing your exam. We would like for your exam to be as pleasant as possible. MRI uses no radiation and you should feel no discomfort while here. I have informed the technologist that I do not have any metallic devices, such as a pacemaker, implants, cerebral aneurysm clips in my body or any metallic foreign bodies in my eyes.

I hereby authorize (Open Air MRI of Miss-Lou) to release and/or receive any and all information: (1) information requested by my insurance company or worker's compensation carrier; (2) information to any hospital or physician I may be referred to and/or (3) information from any hospital or physician who has previously rendered me treatment. I understand that I am ultimately responsible for payment of any and all charges and if this assignment of claim is rejected. Modified. Or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full.

I hereby authorize payment of MEDICAL BENEFITS to Open Air MRI of Miss-Lou I.

PATIENTS NAME (PRINT): _____

SIGNATURE OF PATIENT: _____

DATE: _____

WITNESS: _____

NOTE: Any disclosure of Medical Record information by the recipient is prohibited except when implicit in the purpose of disclosure.