OCMRI
17150 Euclid Street, Suite 101
Fountain Valley, California 92708
(714) 957-0317 FAX: (714) 957-0616

CT SCAN PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ CHART NO: _____
LAST FIRST

AGE: _____ BIRTH DATE: _____ SEX: M / F

HIGHT _____ WEIGHT _____ EXAM: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

WHAT IS THE **REASON** YOUR DOCTOR **ORDERED** THIS **C.T. SCAN**?

DO YOU HAVE:	YES	NO
ALLERGIES?	( )	( )
ASTHMA?	( )	( )
KIDNEY FAILURE?	( )	( )
HEART TROUBLE?	( )	( )
DIABETES?	( )	( )
INSULIN DEPENDENT?	( )	( )
ARE YOU ON METFORMIN (GLUCOPHAGE) PILLS?	( )	( )
REACTION / ALLERGY TO X-RAY CONTRAST?	( )	( )
ARE YOU PREGNANT?	( )	( )
CANCER?	( )	( )

ANY **SURGERIES**? _____

_____

HAVE YOU HAD PREVIOUS **CT SCANS**? WHERE? _____

SIGNATURE: _____ **DATE:** _____

PATIENT INFORMATION SHEET

OCMRI
MRI-PET-CT

Chart No. _____

Scan _____

Insurance _____

Date and Time of Appointment: _____

PATIENT INFORMATION

Patient Name: _____ Driver's License No. _____

Address: _____

City, State Zip: _____ Date of Birth: _____

Telephone (Home): _____ Telephone (Work): _____

Social Security Number: _____

Emergency Contact Name _____ Telephone _____

REFERRING SOURCE

Doctor: _____ Chiropractor: _____ Other: _____

Name of Referring Source: _____ Telephone: _____

INSURANCE INFORMATION

Subscriber Name _____ Subscriber SS#: _____

Relation to Patient _____ Policy No. _____

Primary Ins _____ **Second Ins** _____

Group No. _____ Group No. _____

Member No. _____ Member No. _____

Address _____ Address _____

_____ _____

I authorize payment of medical benefits to Orange County MRI for medical services

Signature: _____

I also authorize release of medical information to process any claims

Signature: _____ Date: _____