OCMRI
MRI-PET-CT

17150 Euclid Street, Suite 101
Fountain Valley, California 92708

PRE SCAN PATIENT INFORMATION SHEET

Patient Name: _____ Chart No._____

Weight: _____ Height: _____ Date of Birth: _____ Sex: M ( ) F ( )

Physician Name: _____ Exam: _____

Physician Phone: _____ Insurance: PI ( ) W/C ( ) Ins ( )

Please answer completely

DO YOU HAVE:	YES	NO
Pacemaker	( )	( )
Brain Aneurysm	( )	( )
Ear Implants	( )	( )
Stents	( )	( )
Dentures or partial plates	( )	( )
Metal in eyes	( )	( )
Mechanical Implants	( )	( )
Medication Pump	( )	( )
Spinal Stimulator	( )	( )
Surgical or Vascular clips	( )	( )
Are you pregnant?	( )	( )
Kidney failure/problems	( )	( )

Date of Injury: _____ Work related: Y N Auto Accident: Y N

Have you had any surgeries? If yes, please explain: _____

_____

_____

Please explain any symptoms that you have now: _____

_____

_____

Have you had previous MRI scans? _____

Have you had x-rays taken? _____

_____

If you have any other questions or concerns please direct them to the technologist

_____

Signature: _____ Date:_____

PATIENT INFORMATION SHEET

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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: _____