PRECISION MRI AND DIAGNOSTIC

Patient Registration Form

6009 Richmond Ave., Ste. 120 Houston, TX 77057
Monday-Friday: 8:00am-5:00pm
Ph: (832)767-5997 Fax: (832)767-5987

PATIENT INFORMATION

Patient Name: ____ SS# ______________
First Name Middle Last Name

DOB: ____/ ____/ _____ Age: _____ Sex: ☐ M ☐ F Weight ______ Height______

Home Address: ____________________________________ Home Phone (___) ____-_______

City: _____________________ State: _____ Zip: ______ Cell Phone (___) ____-_______

Is the patient a minor? ☐ Yes ☐ No If yes, Parent/Guardian name: ____________________________

In case of an emergency, who should we notify? _________________ Phone (___) ____-______

Your email address: ____

Who may we thank for referring you? ____

PRIMARY INSURANCE

Primary Insured: ____

Primary Insured's Address: ______________________ City __________ State _____ Zip _____

Relation to Patient: ________________ DOB ______________ SS#_________________

Do you have a secondary insurance? ☐ Yes ☐ No

If yes, insured's Name _____________ Insured's DOB ____________ Please provide Insurance Card

WORKER'S COMPENSATION

Type of Accident ____________ Work Related? ☐ Yes ☐ No Date of Injury _______________

Claim # ____________________ Adjuster Name _______________ Phone (___) ____-______

Employer at time of injury ______________________________ Phone (___) ____-______

Employer Address: __________________________ City _________ State ______ Zip ________

ATTORNEY GUARANTEE

Type of Accident ____________ Date of Accident ____________________

Attorney Name _______________________________ Phone (___) ____-_______

Attorney Address __________________________ City _________ State ______ Zip ________

Precision MRI has accepted your Letter of Protection from your attorney. The letter of protection that your attorney has provided only postpones the payment of these services to the time of settlement of your case. Ultimately these charges will need to be paid in full and are your responsibility.

HIPPA COMPLIANCE

I have read and understand the HIPPA Privacy Practice document. A copy will be provided upon my request.

______________________	________________	________________	___________
Responsible Party Signature	Printed Name	Relationship to Patient	Date

Patient Questionnaire

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Welcome to Pricision MRI and Diagnostic

Please help us to provide you with the best care and to ensure your safety by completing the following questionnaire. **Any implanted or embedded metal in your body may affect the quality of the examination and/or your safety.** Before your MRI, please remove all metallic objects including keys, hairpins, jewelry, watch, safety pins, paper clips, money clips, credit cards, pens, belt, metal buttons, picket knife, etc. If you have any questions, or concerns, please ask your technologist or the doctor on staff.

Do you have or have you had any of the following:

AIDS	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Dialysis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Earrings or other piercings	☐ Yes	☐ No
Heart Defibrillator	☐ Yes	☐ No	Tattoos	☐ Yes	☐ No
Aneurysm, aortic, vascular clips	☐ Yes	☐ No	Permanent Makeup	☐ Yes	☐ No
Neurostimulator	☐ Yes	☐ No	IUD or diaphragm	☐ Yes	☐ No
Bone growth/fusion stimulator	☐ Yes	☐ No	Dentures	☐ Yes	☐ No
Shunt (spinal or intraventricular)	☐ Yes	☐ No	Ear implant or Hearing aid	☐ Yes	☐ No
Intravascular stents, filters or coils	☐ Yes	☐ No	Artificial limb or joint	☐ Yes	☐ No
Vascular access port or catheter	☐ Yes	☐ No	Implants of any kind	☐ Yes	☐ No
Carotid artery vascular pump	☐ Yes	☐ No	Any type of prosthesis	☐ Yes	☐ No
Insulin or infusion pump	☐ Yes	☐ No	Surgical staples or wires	☐ Yes	☐ No
Metal implants	☐ Yes	☐ No	Bone/joint screw, nail, rods, etc.	☐ Yes	☐ No
Metal fragments in eyes	☐ Yes	☐ No	Anxiety or breathing disorder	☐ Yes	☐ No

Please list any other medical conditions not listed above

____

Explain present condition (How and when were you injured? Where is your pain? And for how long?)

____

List any past injuries

____

FEMALE PATIENTS ONLY

Are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle ____________________

There are NO known complications for pregnant patients from an MRI procedure.

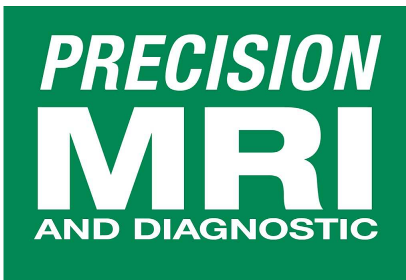
I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of, and I have had the opportunity to ask questions regarding the information on this form.

Date _______________

____

Patient or Authorized Signature

Completed by: ☐ Patient ☐ Relative ☐ Physician ☐ Other _____________



MEDICAL RECORDS RELEASE FORM

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GENERAL MEDICAL RECORD RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name ____
First Middle Last Name

Address ________________________________ City _________________ State _______ Zip _________

Phone (_____) ______- ___________ SS# _____-____-______ Date of Birth _____/ _____/ ________

I authorize Precision MRI and Diagnostic to release all my medical records. All Medical records, including but not limited to radiology recordis including X-ray, MRI, MRA, Ultrasound, DEXA.

Please send to: ____

These records are for services provided on the following dates: ________________________________

If medical records are being released to patient:

Has your doctor discussed these results with you? ☐ Yes ☐ No

If yes, on what date?: __________________

______________________________ Date: ________/ ________/ __________
Patient / Guardian Signature

__________________________________ __________________________________
Witness Relationship