

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 ____

Houston 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

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

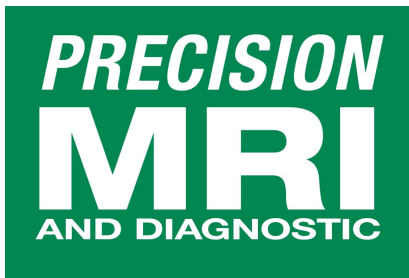
There are NO known complications for pregnant patients from an MRI procedure.

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

6009 Richmond Ave., Ste. 120 Houston, TX 77057

Monday-Friday: 8:00am-5:00pm

Ph: (832)767-5997 Fax: (832)767-5987

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 records 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?: _____

Patient / Guardian Signature

Date: ____/____/____

Witness

Relationship