

PERSONAL PATIENT INFORMATION

Patient Name: _____ Birthdate: ____/____/____
Last First M.I.

DO YOU HAVE A PACEMAKER? _____ SEE RECEPTIONIST Sex: M F

Mailing Address: _____
Street City, State, Zip

Home Phone: _____ Other Phone: _____ SSN: _____ - _____ - _____

Employer: _____ Married _____ Single _____ Child _____

Referring Doctor: _____ Primary Care Doctor: _____

Primary Ins. Subscriber (if different from patient) Name: _____ Date of Birth: _____

Secondary Ins. Subscriber Name: _____ Date of Birth: _____

_____ Insurance _____ Workers Comp _____ Auto _____ Self

Some of the following items may be hazardous to your safety or may interfere with the MRI study. Please check any item that may pertain to you.

YES NO

YES	NO	Have you ever been a machinist, welder or sheet metal worker?
YES	NO	Have you ever had a piece of metal removed from your eye or face?
YES	NO	Do you have a personal history of cancer? If yes: _____
YES	NO	Are you pregnant, possibly pregnant, or breast feeding?
YES	NO	Are you allergic to any medications? If yes, list: _____
YES	NO	Do you have claustrophobia?

Do you have the following items on your person today?

YES NO

YES	NO	Cardiac Pacemaker or Defibrillator
YES	NO	Medication Patch
YES	NO	Implanted Stimulator or Pump
YES	NO	Aneurysm, Carotid or Surgical Clips
YES	NO	Metal Screws, Plates, Wires, Staples
YES	NO	Artificial Limb, Joint or Metal Implants

YES NO

YES	NO	Shunt, Coil, Stent - Present card to receptionist.
YES	NO	Hearing Aid, removable or implanted
YES	NO	Removable Dentures, Partials, Retainers
YES	NO	Body Piercing (other than ears)
YES	NO	Shrapnel or Bullets, BBs or pellets
YES	NO	Any other metal in your body

Please list your approximate weight: _____ lbs. Date of Injury or pain started: _____

What are we scanning today?: _____

List any surgery you have had on the body part we are scanning today: _____

Have you had X-rays, CT or MRI scans, or ultrasound on the body part we are scanning? Yes No

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and the MRI procedure that I am to undergo. I understand that the facility is not responsible for valuables and personal property brought to the facility.

Signature: _____ Date: _____

CONTRAST SCREENING AND CONSENT

Your physician may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

Do you have asthma? YES NO Do you have diabetes? YES NO
 Do you have renal (kidney)disease? YES NO Have you had an organ transplant? YES NO
 History of blood clots in veins/artries? YES NO

Have you had an MRI with contrast before? YES NO Did you have a reaction? YES NO

I have read and understand the above information, and have had my questions answered. I agree to have the MRI procedure and injection of contrast if deemed necessary.

Signature: _____ Date: _____