ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Sex: ___Male _____Female

HOME ADDRESS _____

MAILING ADDRESS _____

PRIMARY CARE PHYSICIAN _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER - INFORMATION:

CURRENT EMPLOYER _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE NUMBER _____

SPOUSE - INFORMATION:

SPOUSE'S NAME _____ SPOUSE'S DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S EMPLOYER _____

SPOUSE'S EMPLOYER PHONE NUMBER _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

PRIMARY INSURED NAME (IF OTHER THAN PATIENT) _____ RELATIONSHIP _____

PRIMARY INSURED DOB: _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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AREA TO BE EXAMINED / TYPE OF EXAMINATION:_____

DIAGNOSIS OR CLINICAL SUSPICION_____

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? _____ Yes _____No

If yes: What _____When _____Where_____

_____Yes _____No Have you ever smoked? If yes for how long?_____ How many packs a day?_____ If you are an ex-smoker, how long ago did you quit? _____

_____Yes _____No Cancer?

If yes: What type _____Where_____
Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

_____Yes _____No Are you **pregnant**? Date of last menstrual period:_____

List recent surgeries:_____

Patient or Legal Representative Signature: _____ Date:_____

Witness or Interpreter Signature :_____ Date:_____

Technologist Signature: _____ Date:_____

Additional comments:_____

_____

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PATIENT CONSENT FORM

By signing this form, you are granting consent to Advanced MRI and Imaging to use and disclose your protected health information for the purpose of treatment, payment, and health care operations as well as any ordered testing or imaging

Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review out notice of privacy practices before you sign this consent.

Our notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from our office.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your original consent.

_____
Patient name (please print above)

_____ _____
Patient Signature Date

_____
Witness name (please print above)

_____ _____
Witness signature Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

_____ Spouse

_____ Significant other

_____ Family Member (name: _____)

_____ Caregiver

_____ Answering Machine

_____ Send artificial, prerecorded, or automated calls and test messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

_____

Signature of Patient (of parent/guardian or minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR OFFICE USE ONLY

Print Name: _____

Signature: _____ Date: _____