ADVANCED MRI AND IMAGING

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

Diagnostic Study Registration Form(MRI)

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: _____ SS NO _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ADVANCED MRI AND IMAGING

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

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

If yes: What _____When _____Where_____

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? _____

Cancer _____Yes _____No

If yes: What type _____Body Part _____

Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

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

_____Yes _____No Are you currently **breast feeding?**

FOR PATIENTS GETTING MRI WITH CONTRAST :

IV Contrast History:

Do you have any personal history of: **Diabetes:** _____Yes _____No

Kidney disease: ____Yes _____ No Kidney surgery: ____Yes _____No

Contrast allergy_____Yes _____No Patient premedicated for exam_____Yes _____No_____

FOR TECHNOLOGIST ONLY

IV contrast given: Contrast type _____Amount_____(CCs)IVsite_____

BUN _____CREATININE_____GFR _____ Date_____

Contrast reaction: _____Yes ____No Discharge instructions given for contrast reaction: ___Yes __NO

ATTENTION MR PATIENTS AND ACCOMPANYING FAMILY MEMBERS

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan and even be dangerous, so please answer the following questions carefully. This is particularly important with regards to prior surgery on the part of the body which we will be scanning.

ADVANCED MRI AND IMAGING

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

MRI cannot be performed if Yes is answered to the following four Questions. Please read Completely and check those that apply.

PACEMAKER, wires or defibrillator	☐ Yes / ☐ No
Brain/aneurysm clip	☐ Yes / ☐ No
Tissue expander for future implants e.g Breast.	☐ Yes / ☐ No
Small Bowel Endoscopy Capsule	☐ Yes / ☐ No

Please Indicate If You Have Any Of The Following Items In Your Body:

Ear implant or **HEARING AID** (must be removed prior to MRI)	☐ Yes / ☐ No
Infusion pump, or medication pump of any kind	☐ Yes / ☐ No
Do you have claustrophobia (fear of enclosed spaces)?	☐ Yes / ☐ No
Eye implant or eyelid implant	☐ Yes / ☐ No
Electrical stimulator for nerves or bone, spinal cord	☐ Yes / ☐ No
Magnetic implant (anywhere in the body)	☐ Yes / ☐ No
Skin patch for medication	☐ Yes / ☐ No
Coil, filter, or wire in a blood vessel	☐ Yes / ☐ No
Artificial limb or joint	☐ Yes / ☐ No
Eyelid tattoo , body piercings	☐ Yes / ☐ No
Implanted catheter or tube	☐ Yes / ☐ No
Artificial heart valve , Cardiac stents	☐ Yes / ☐ No
Penileprosthesis(Duraphase and Omniphase are CI)	☐ Yes / ☐ No
Shunt spinal or intraventricular	☐ Yes / ☐ No
False teeth, retainers, or magnetic braces, dentures	☐ Yes / ☐ No
Surgical clips, staples, wires, mesh, or sutures	☐ Yes / ☐ No
Recent surgery (in the last **6-8 weeks**)	☐ Yes / ☐ No
Intrauterine device (IUD)	☐ Yes / ☐ No
Orthopaedic hardware (plates, screws, pins, rods, wires)	☐ Yes / ☐ No
Bullets, BBs or pellets	☐ Yes / ☐ No
Metal shrapnel or fragments	☐ Yes / ☐ No
Have you ever been a machinist, welder or metal worker?	☐ Yes / ☐ No
Have you ever been hit in the face or eye with a piece of metal (including shavings, slivers, bullets or BBs)?	☐ Yes / ☐ No
Have you ever had a piece of metal removed from your eye?	☐ Yes / ☐ No

The normal function of the MR unit generates electrical currents which may create a sensation of warmth, either in the sides of the imaging unit or in the surrounding coil. If you experience any focal warmth that leads to discomfort, please notify the technologist immediately.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. I understand that it is my responsibility to inform the office of any metal and/or any devices that may be in my body, be failing to do so may cause serious bodily injury or be life-threatening. I agree that should I have any metal in my body and after consultation with a physician, elected to proceed with the MRI, I agree to release advanced MRI and Imaging from any and All liability for any injury,

Patient or Legal Representative Signature: _____ Date:_____

Witness or Interpreter Signature :_____ Date:_____

ADVANCED MRI AND IMAGING

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

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 our 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

ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-0060 • Fax: (863) 386-0062

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: _____