8149 South Kennedy Avenue, Suite A
Highland, IN 46322

CT SCAN - OPEN MRI
X-RAY - DEXA - ULTRASOUND

Phone: 219-923-8540
Fax: 219-923-6742

Registration Form

Please print and complete all entrees

Patient Name: ______________________ First Visit? YES NO

Address: ______________________ Email address: ______________________

City/State/Zip: ______________________ ______________________

Home Phone: ( ) __________ Cell:( ) __________ Work:( ) __________

SS#: __________ D.O.B. __________ Sex: M F Marital Status: S M D W

Employer: ______________________ Address: ______________________

Occupation: ______________________ Full Time / Part Time / Student

Emergency Contact: ______________________ Phone: ( ) __________

Referring Physician: ______________________ Primary Physician: ______________________

Who will be responsible for your account? Self / Spouse / Father / Mother / Other

Name: ______________________ SSN: __________ Phone: ( ) __________

Address: ______________________ City/St/Zip: ______________________

Employer: ______________________ Phone: ( ) __________

Primary Insurance Information:

Ins Co Name: ______________________

Policy Holder Name: ______________________

Relationship to Patient: ______________________

Policy Holder's Employer: ______________________

SSN/ID#: ______________________

Policy/Group#: ______________________

Policy Holder's Birthdate: ______________________

Secondary Insurance Information:

Ins Co Name: ______________________

Policy Holder Name: ______________________

Relationship to Patient: ______________________

Policy Holder's Employer: ______________________

SSN/ID#: ______________________

Policy/Group#: ______________________

Policy Holder's Birthdate: ______________________

Work Related? YES NO

Auto Accident? YES NO

Injury Date: ______________________

Phone # ______________________

Claim # ______________________

Is an attorney involved? YES NO

Attorney Name: ______________________

Phone: ______________________

______________________ ______________________ ______/______/______

Name Signature Date

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MRI History Sheet

Patient Name: ______________________________

What was the main health complaint that caused your physician to order your scan? ______________

____

Have you ever had an MRI scan of the body area we are going to scan today? Y N

Y N Could you be pregnant?
Y N Are you nursing?

Y N History of Cancer?
If so, what type ____________
Y N Recent Surgery
If so, what type ____________

MRI Safety Questions: Please circle "Yes" or "No" to each question:

Y N Have you ever done **metal work** such as cutting, welding, or using a grinder?
Y N **If YES**, have you ever **had metal fragments lodged in your eyes**?
Y N Have you ever had any heart surgery?
Y N **If YES**, do you have a **Pacemaker, stent or Artificial Heart Valve**?
****If you have a Pacemaker or Artificial Heart Valve, please inform the technologist at this point.****
Y N Have you ever had any **head surgery**?
Y N **If YES**, do you have any clips, such as **aneurysm clips**, and if so, what year were they inserted? ____________________
Y N Have you ever had any **ear surgery**?
If YES, what type and when was the surgery performed? ______________
Y N Have you ever had any **surgeries to do with the body part** being scanned?
If YES, what type and when was the surgery performed? ______________
Y N Do you have any **implanted metal** in your body (i.e. due to surgery, shrapnel, bullets, etc.)?
Y N Do you have any **dental implants**, **bridgework**, or **dental plates** that are removable?
Y N Do you have any **artificial** or **prosthetic** limbs.
Y N Do you have other implants, pins, mesh, wires, pumps or device?
If YES what type? ____________________
Y N Do you have any other medical conditions? Please list: ____________________
Y N Do you have a **hearing aid** or an **ear implant**?
Y N Do you have any **permanent tattoos** or **permanent makeup**?
Y N Are you **claustrophobic** (fear of being in small, confined places)?

All jewelry, hairpins, electrodes and wigs must be removed prior to entering the MRI scan room

Patient Signature: ______________________ **Date:** ____/____/____
Parent Signature (if minor): ______________________ **Date:** ____/____/____