Baymeadows MRI & X-RAY

Chart No _____

Date: _____

Patient Information and Insurance Form

Please Print:

Patient Information:

Last _____ First _____ Mi _____

Address _____Lot/Apt#_____

City/State/Zip _____

Phone (_____)_____Work Phone (_____)_____

Cell Phone (_____)_____ Sex: [ ] M [ ] F Martial Status: _____

Date of Birth _____ Social Security # _____

Emergency Contact _____ Phone (_____)_____

Referring Physician _____Phone (_____)_____

Employer Name _____

Address _____ Phone (_____)_____

Insurance Information

Primary Insurance _____

Claims Address _____

Member Id Number _____ Group Number _____

Secondary Insurance _____

Claims Address _____

Member Id Number _____ Group Number _____

Primary Policy Holder If Different Than Patient:

Last _____ First _____ Mi _____

Address _____Lot/Apt#_____

City/State/Zip _____

Phone (_____)_____Work Phone (_____)_____

Cell Phone (_____)_____ Sex [ ] M [ ] F Martial Status _____

Date Of Birth _____ Social Security # _____

Baymeadows MRI & X-RAY

Chart No _____

Date: _____

MRI Screening Form

MRN # : _____ Date: _____

Name: _____ Age: _____

Please circle YES or NO for the following questions:

Are you claustrophobic?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have brain aneurysm clips?	Yes	No
Do you have cochlear implants?	Yes	No
Do you wear a hearing aid?	Yes	No
Have you ever worked with welding or metal grinding?	Yes	No
Have you ever had metal fragments in your eyes?	Yes	No
Do you have any stints in your body?	Yes	No
Have you ever had back or head surgery?	Yes	No
Do you have metal plates, screws, nails or clips in your body?	Yes	No
Do you have aortic clips?	Yes	No
Do you have an artificial heart valve?	Yes	No
Do you have a shunt (spinal or ventricular)?	Yes	No
Are you wearing a Tens Unit for pain?	Yes	No
Do you have an insulin pump?	Yes	No
Have you ever had a joint replacement?	Yes	No
Do you have ROGO rods in your back?	Yes	No
Do you have any type of prosthesis?	Yes	No
Do you have any wire sutures?	Yes	No
Do you have any shrapnel in your body?	Yes	No
Do you have permanent cosmetic eyeliner?	Yes	No
Do you wear dentures or partials?	Yes	No
Female patients only:		
Do you have a Pessary Ring?	Yes	No
Do you have an IUD?	Yes	No
Is there any chance you might be pregnant?	Yes	No

List all the surgeries you have had:

_____

_____

_____

_____

_____

_____

_____

What is your weight? _____ What is your height? _____

Please remove *all* jewelry and hairpins and use the restroom while you are waiting.
– Thank You.

Patient Signature _____ Technologist: _____

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