



Today's Date: _____
(Fecha)

Registration Form

PATIENT INFORMATION

Last Name: _____ (Apellido)	First Name: _____ (Nombre)	M.I.: _____	
Birthdate: _____ (Fecha de Nacimiento)	Age: _____ (Edad)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F (Sexo)	
Address, Apt #: _____ (Domicilio, Numero y Calle)	City: _____ (Ciudad)	State: _____ (Estado)	Zip: _____ (Zona Postal)
Home Phone: _____ (Telefono de Casa)	Cell Phone: _____ (Telefono de Celular)		
Driver's Lic. #: _____ (Numero de Licencia para Conducir)	SSN Patient: _____ (Numero de Seguro Social)		
Employer: _____ (Compañia de Trabajo)	Telephone: _____ (Telefono de su Trabajo)		
Emp. Address: _____ (Domicilio, Numero y Calle)	City: _____ (Ciudad)	State: _____ (Estado)	Zip: _____ (Zona Postal)

INSURANCE INFORMATION

Primary Ins.: _____ (Seguanza Primaria)	Subscriber #: _____ (Numero de a siguranza)	Group #: _____ (Numero de Grupo)	
Insured Name: _____ (Nombre de Su Esposo(a), o Persona Responsable)	Relationship: _____ (Relacion)	Phone: _____ (Telefono)	
Insured Lic. #: _____ (Numero de Licencia para Conducir)	SSN Insured: _____ (Numero de Seguro Social)		
Employer: _____ (Compañia de Trabajo)	Telephone: _____ (Telefono de su Trabajo)		
Emp. Address: _____ (Domicilio, Numero y Calle)	City: _____ (Ciudad)	State: _____ (Estado)	Zip: _____ (Zona Postal)

MEDICAL INFORMATION

Doctor who referred you to our office: _____
(Nombre del doctor quien lo mando)

Was there an injury? Yes No Date of Injury _____ Type of Injury: WORK PERSONAL
(Fue un Herida) (Fecha de Herida) (Tipo de Herida) (Trabajo) (Personal)

SIGNATURES

I attest that the information provided on this form is true to the best of my knowledge. I understand that ALL fees are due from ALL PATIENTS as services are rendered, unless prior arrangements have been made with this office. I understand that Insurance Authorization does not guarantee payment and I am responsible for all charges. Please Return this form with your Driver's License and Insurance Card.

(Atesto que toda la informacion en esta forma es real y verdadera de acuerdo a mi conocimiento. Entiendo que todos las tarifas de los servicios son desponibles al tiempo que los servicios son realizados. Entiendo que autorizacion del seguro no garantiza el pago y que yo soy responsable por todos los cargos. Favor de regresar esta forma con su lisencia de conductor y tarjeta de su seguro medico.)

Signature of Patient

Date



MRI Screening and History

PATIENT NAME: _____ D.O.B.: _____ WEIGHT: _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. DO NOT ENTER the MRI scan room if you have any questions or concerns.

HAVE YOU BEEN HERE BEFORE? YES NO When? _____

HOW DID YOU HEAR ABOUT US? _____

If you have any of the following items inside your body, ***please Indicate***

- YES NO Cardiac Pacemaker YES NO Medication Skin Patch
- YES NO Brain Aneurysm Clips YES NO Tattoo or Permanent Makeup
- YES NO Carotid Artery Vascular Clamp YES NO Penile or Testicular Implant
- YES NO Infusion Pump YES NO IUD or Pessary.
- YES NO Implanted Cardiac Defibrillator YES NO Dentures or Braces
- YES NO Shrapnel, Bullets, Pellets, or Metallic Fragment YES NO Neurostimulator
- YES NO Electronic Implant, Wires or Device YES NO Heart Valve Prosthesis
- YES NO Eye Implants or Prosthesis YES NO Harrington Rods
- YES NO Shunt YES NO Hearing Aid
- YES NO Intravascular Stent, Filter, Coil Where: _____ When: _____
- YES NO Metal Screws, Plates or Rods Where: _____ When: _____
- YES NO Joint Replacement Hip Knee Shoulder
- YES NO Other: _____
- YES NO Have you ever had an injury to the eye involving a metallic object fragment, shavings, or grindings?
Possible: YES NO What: _____ When: _____
- YES NO Could you be pregnant?
- YES NO Are you breast feeding?
- YES NO Any known allergies? Please List: _____
- YES NO Do you have a history of cancer? Type: _____ When: _____
- YES NO Have you taken any sedatives today? Type: _____ When: _____

I have read the above information and answered to the best of my knowledge. I hereby give consent to have an MRI scan. I have directed all of my questions to my Doctor or the MRI staff.

Please notify the receptionist if you marked YES to any of the above questions.

PATIENT SIGNATURE: _____ TODAY'S DATE: _____

You are scheduled for an MRI of: _____

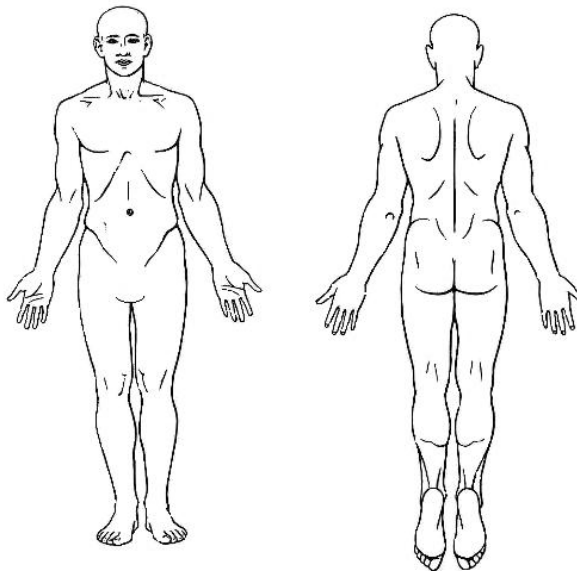
Please describe any symptoms or problems involving the area of your body being scanned today:

How long have you had your symptoms? _____

Please list any previous surgeries or fractures involving the area of your body being scanned today:

Have you had any previous studies on the same area of your body being scanned today? If so, please list the scan type, when and the facility name that performed scan.

If today's study is being done because of PAIN, NUMBNESS or WEAKNESS, please circle/shade those body areas on the diagram below:



Signature _____ Date: _____



MRI GADOLINIUM CONSENT / FDA EVALUATION ALERT

Your doctor has asked us to perform an MRI examination with contrast material called Gadolinium. During this test, a gadolinium-contrast agent is injected into a vein resulting in diagnostic information and distinguishing neighboring tissue.

The Federal Drug Administration (FDA) is currently evaluating important safety information about gadolinium-containing contrast agents and a disease known as Nephrogenic Systemic Fibrosis or Nephrogenic Fibrosing dermopathy (NSF / NFD) that can occur in patients with kidney failure. New reports have identified a possible link between NSF / NFD and exposure to gadolinium containing contrast agents used for Magnetic Resonance Imaging, in patients with advanced renal failure.

NSF / NFD causes fibrosis of the skin and connective tissues throughout the body. Patients develop skin thickening that may prevent bending and extending joints, resulting in decreased mobility in joints. In addition, patients may experience fibrosis that has spread to other parts of the body such as the diaphragm, muscles in the thigh and lower abdomen, and the interior areas of lung vessels. The clinical course of NSF / NFD is progressive and may be fatal.

After having been informed and having the opportunity to ask questions in regards to this procedure, I am aware of the possible risks of gadolinium as a result of this MRI exam and consent to this study.

Signature: _____ Date: _____

Signature of Witness: _____ Date: _____