

Chart # _____ APPT BY: _____
 Patient Name _____ DOB _____
 Address _____ APT# _____ City _____ Zip _____
 Phone # _____ SS# _____ Email: (appointment alerts) _____

| |
|---|
| Work status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student |
| Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |
| How were you referred to our office <input type="checkbox"/> Referring Dr <input type="checkbox"/> Internet <input type="checkbox"/> Zoc Doc <input type="checkbox"/> Returning Patient <input type="checkbox"/> ETC. _____ When is your follow up appointment with your doctor regarding this study? _____ |

Employer _____ Employer's Address _____
 Emergency contact person _____ phone # _____

INSURANCE INFORMATION

| | |
|--|--|
| Is this related to an accident | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes, <input type="checkbox"/> Auto, <input type="checkbox"/> W.Comp. <input type="checkbox"/> Other |
| Date of accident : _____ | State Auto Injury occurred in: _____ |
| Attorney Name: _____ | Phone# _____ |
| Are you treating with a Chiropractor <input type="checkbox"/> Yes <input type="checkbox"/> No | Name: _____ Phone: _____ |

PRIMARY

Authorization # _____

| | | |
|-----------------------|-------------------------|--------------------|
| Name Insurance: _____ | Id # _____ | Group # _____ |
| Phone # _____ | Insurance Address _____ | Adj Info _____ |
| Subscriber name _____ | D.O.B/ S.S.# _____ | Relationship _____ |

SECONDARY

Authorization # _____

| | | |
|-----------------------|-------------------------|--------------------|
| Name Insurance: _____ | Id # _____ | Group # _____ |
| Phone # _____ | Insurance Address _____ | Adj Info _____ |
| Subscriber name _____ | D.O.B/ S.S.# _____ | Relationship _____ |

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare patients) and all other third party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand if my account is sent to collection for payment, I will incur additional charges (a minimum of 25%) on the amount sent; this applies to co payments as well. This is for today's service and any future services at Middletown Medical Imaging. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

This facility will provide a locker in which you must store your personal items and valuables. Please lock these items in the area provided, and bring the key with you into the scan room for security. Middletown Medical Imaging will not accept liability for any personal belongings.

I hereby authorize Middletown Medical Imaging to deliver my imaging studies to the referring physician or specialist at his/her request. I understand that these studies are a permanent part of my medical record. I hereby release Middletown Medical Imaging from any and all legal responsibility or liability that may arise from release of these films. I have been offered a copy of the HIPPA compliance and understand and agree to its terms.

Signature

Today's date

All patients/legal guardians must REVIEW, SIGN and DATE all paperwork.

MRI QUESTIONNAIRE

APPOINTMENT DATE: _____ **APPT. TIME** _____ **ARRIVAL TIME:** _____
Do You Have A Follow-up Appt. with your Doctor? _____ **When?** _____

Patient's Name _____ **DOB** _____ (Circle) Male/Female

Type of Scan _____ **R/O** _____ **Height** _____ **Weight** _____

Referring Physician _____ **Phone #** _____

SAFETY QUESTIONS

| | |
|--|--|
| Are you claustrophobic? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Do you have a Pacemaker/Defibrillator | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Do you have aneurysm clips | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Have you ever had metal go into or removed from your eyes | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Are you a welder, sheet metal worker or grind with metal | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Have you ever had any <input type="checkbox"/> BRAIN <input type="checkbox"/> HEART <input type="checkbox"/> EAR/EYE surgery | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Have you had any surgery or procedure that left any device, implant, stents, wires or stimulators in your body | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A WHERE: _____ |
| Do you have a tissue expander implanted | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Do you have removable dentures or hearing aids | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Do you have any tattoo eyeliner | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Are you wearing any medicated patches | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Do you have any metal or mechanical devices hooked up or inside of you | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Are you pregnant | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Can you walk without assistance | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A EXPLAIN _____ |

CLINICAL QUESTIONS

| | |
|--|---|
| Have you had any previous exams of the same body part? **OBTAIN REPORT** | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Yes, Where/When: _____ |
| Have you had SURGERY of the body part we are scanning today If YES, what type: _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Do you or have you ever had any type of Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Yes, What: _____ |

CONTRAST QUESTIONS

****PATIENTS NEED TO DRINK AT LEAST 2 8OZ GLASSES OF WATER PRIOR TO EXAM****

| | |
|---|--|
| Have you had MRI Contrast (Injection) before | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Yes, please list any allergic occurrence: _____ |
| Have you been diagnosed with Kidney disease or Kidney failure | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Are you on Dialysis (If so Patient MUST schedule Dialysis after Scan) | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| Are you Diabetic | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |

****Any patient with diabetes, kidney failures or over 60 must have blood work. (Labs: BUN, GFR, Creatinine)****

.....
 I have reviewed the above information provided in the telephone screening, and it is correct. I hereby give permission to North Dover Radiology to perform this MRI exam.

Patient/Guardian Signature: _____ **Date:** _____

Attachments: Prior Exam Blood work Script

Front Desk Only: Date: _____ **CONFIRMED** **LEFT MESSAGE** **NO ANSWER**

For Contrast studies: **instructed patient to drink water**



MIDDLETOWN MEDICAL IMAGING

3T MRI • Open MRI • Low Dose CT • Ultrasound • Digital X-Ray

CLINICAL QUESTIONNAIRE

Name: _____ Date: _____

Allergies: _____

- Why has your doctor sent you for this test? Did she/he give you a specific diagnosis?

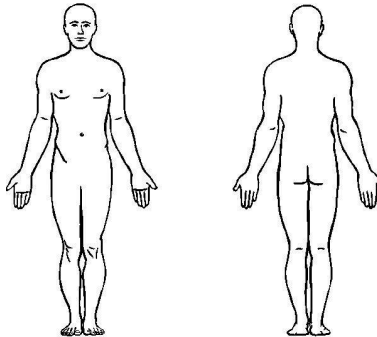
- Please describe what specific complaints/symptoms have been most bothersome to you?

- How long have you had these complaints/symptoms? _____
- Did these complaints/symptoms come on suddenly or gradually? _____
- These complaints/symptoms have:
_____ improved _____ remained the same _____ worsened
- Have you had any previous surgery related to today's exam? ___ Yes ___ No
(If Yes, type and date: _____)
- Have you had any prior tests related to today's exam, if so what were the results of the test? _____
- Do you have any history of any cancer? ___ Yes ___ No
- Do you have a history of smoking? ___ Yes ___ No

FEMALE PATIENTS:

- Are you pregnant? ___ Yes ___ No ___ N/A
- Date of Last Menstrual Period _____

**Circle region
of pain:**



Patient Signature: _____

Date: _____



M I D D L E T O W N
M E D I C A L I M A G I N G

1275 Route 35 N
Middletown, NJ 07748
(732) 275-0999

PATIENT NAME: _____

DOB: ____ / ____ / ____ **PATIENT SOCIAL SECURITY #:** ____ - ____ - ____

REVIEW OF OUTSIDE FILMS POLICY:

Please make available to the front office any prior imaging films, CD's, and reports at the time of your appointment. This pertains solely to any exams performed at any outside facilities other than Middletown Medical Imaging. Please be advised that if you fail to bring your prior exam at the time of your appointment there will be a \$100.00 "Review of Outside Film" charge for any comparison performed after your original appointment date.

DISC AND FILM RELEASE:

I hereby release Middletown Medical Imaging located at 1275 Route 35 North in Middletown, NJ from any and all legal responsibility or liability that may arise from release of records. For any additional disc or films a fee will be charged. The fee for a disc will be \$25.00 and films will cost \$75.00.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby request you to release my medical records to/from Middletown Medical Imaging. Please fax all records to 732-275-0979.

Name of Referring Doctor or Organization: _____
Ph#: _____ FX#: _____

X: _____
SIGNATURE OF PATIENT OR REPRESENTATIVE:

Date: ____ / ____ / ____