

Jacket # \_\_\_\_\_

Study Ordered: \_\_\_\_\_

**Petaluma Open MRI  
Patient Information Sheet**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Number) (City) (State) (Zip)

Phone: (\_\_\_\_) \_\_\_\_\_ Social Sec. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

**Guarantor/Insured Information**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address (if different): \_\_\_\_\_  
(Number) (City) (State) (Zip)

Home #: \_\_\_\_\_ Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

**PLEASE CIRCLE YES OR NO TO THE QUESTIONS BELOW:**

|                                                     |        |                                               |        |
|-----------------------------------------------------|--------|-----------------------------------------------|--------|
| <u>Do you have a pacemaker?:</u>                    | Yes/No | <u>Do you have any stents in your heart?:</u> | Yes/No |
| <u>Have you had metal exposure to your eyes:</u>    | Yes/No | <u>Do you have a brain aneurysm clip?:</u>    | Yes/No |
| <u>Have you ever had a gunshot wound/shrapnal?:</u> | Yes/No | <u>Are you claustrophobic?:</u>               | Yes/No |

|               |        |                    |        |                   |        |
|---------------|--------|--------------------|--------|-------------------|--------|
| Heart Valve   | Yes/No | Previous Surgeries | Yes/No | Penile Implant    | Yes/No |
| Pregnant      | Yes/No | Prosthesis         | Yes/No | Metallic Implants | Yes/No |
| IUD/Diaphragm | Yes/No | Surgical Metal     | Yes/No | Dentures          | Yes/No |
| Infusion Pump | Yes/No | Hearing Aids       | Yes/No | Ear Implants      | Yes/No |

If you have any questions feel free to ask the Technologist performing your exam. We would like for your exam to be as pleasant as possible. MRI uses no radiation and you should feel no discomfort while here. I have informed the technologist that I do not have any metallic devices, such as a pacemaker, implants, cerebral aneurysm clips in my body or any metallic foreign bodies in my eyes.

I hereby authorize (Petaluma Open MRI) to release and/or receive any and all information: (1) information requested by my insurance company or worker's compensation carrier; (2) information to any hospital or physician who has previously rendered me treatment. I understand that I am ultimately responsible for payment of any kind and all charges and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full.

I hereby authorize payment of medical benefits to Petaluma Open MRI.

PATIENTS NAME (PRINT): \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

NOTE: Any disclosure of Medical Record information by the recipient is prohibited except when implicit in the purpose of disclosure.

**\*\* LIST ANY SURGERY YOU HAVE HAD ON THE BODY PART WE ARE SCANNING:**

**\*\*IF BACK SURGERY-WHAT LEVELS DID THEY WORK ON?** \_\_\_\_\_

**\*\*WHAT DATE/YEAR DID YOU HAVE THE SURGERY?** \_\_\_\_\_

**\*\* HOW DID YOU INJURE YOURSELF?**

**\*\* WHEN DID YOU INJURE YOURSELF OR HOW LONG HAVE YOU HAD SYMPTOMS?**

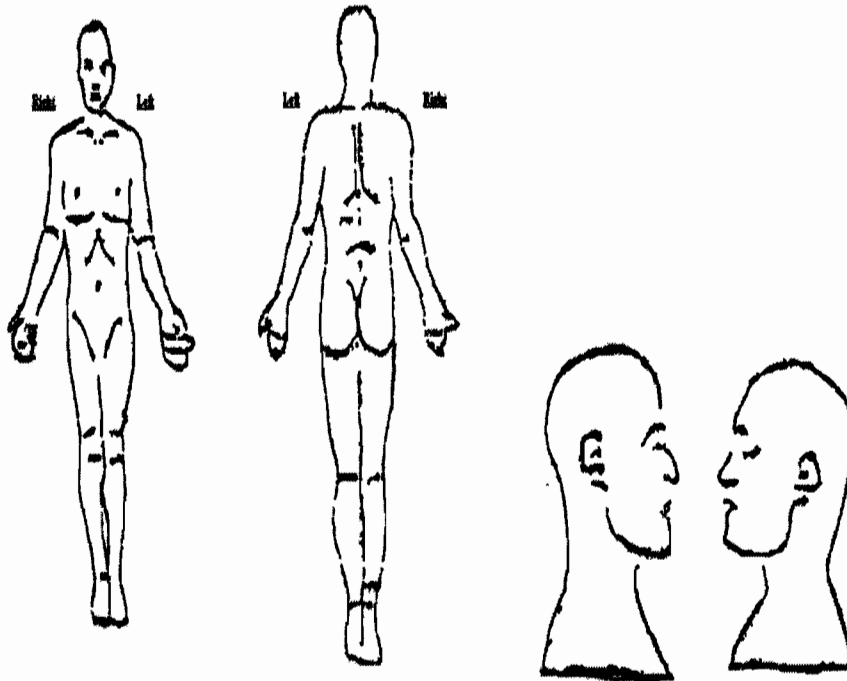
**\*\* CIRCLE SYMPTOMS IF ANY:** Headaches      Seizures      Weakness      Confusion  
Hearing Changes      Visual Changes      Loss of Balance      Dizziness  
Speech Difficulties      Difficulty Walking      Pain/Numbness      Memory Loss

**\*\* HAVE YOU EVER HAD ANY FORM OF CANCER? YES \_\_\_\_\_ NO \_\_\_\_\_**

**\*\* IF YOU ANSWERED YES, WHAT TYPE OF CANCER & WHAT LOCATION OF THE BODY?**

Draw on figure where pain or symptoms are located:

**\*\* DESCRIBE YOUR SYMPTOMS:**



**\*\* PLEASE CHECK ANY PREVIOUS EXAMS YOU HAVE HAD RELATING TO THIS BODY PART.**

\_\_\_\_\_ MRI      \_\_\_\_\_ CT SCAN      \_\_\_\_\_ XRAYs

**IF YES, WHERE (NAME OF FACILITY AND DATE):** \_\_\_\_\_