Cypress Women's Imaging Imaging Center at Cypress

Date_______________ Referring Physician_______________________________

PATIENT		SUBSCRIBER'S NAME	
FIRST NAME (Please Print) Middle Initial		FIRST NAME (Please Print) Middle Initial	
LAST NAME		LAST NAME	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE ZIP CODE		CITY, STATE ZIP CODE	
HOME PHONE	WORK PHONE	HOME PHONE	WORK PHONE
SOCIAL SECURITY NUMBER	CELL PHONE	SOCIAL SECURITY NUMBER	CELL PHONE
EMPLOYER	OCCUPATION	EMPLOYER	OCCUPATION
SEX	MARITAL STATUS	SEX	MARITAL STATUS
BIRTHDATE	AGE	BIRTHDATE	AGE

RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ____________________

NAME, ADDRESS AND PHONE OF PERSON NOT LIVING WITH YOU, TO CONTACT IN CASE OF EMERGENCY

GIVE A BRIEF HISTORY OF YOUR ILLNESS:

INSURANCE INFORMATION	
PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
ADDRESS	ADDRESS
INSURANCE I.D.#	INSURANCE I.D.#
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME

IS INJURY A RESULT OF CAR ACCIDENT? ________________________
(If yes, give name & address of auto carrier in above spaces)

IS X-RAY FOR WORKMANS COMPENSATION?______________________

IF YES, GIVE DATE OF INJURY ________________________________

ACKNOLEDGEMENT OF RECEIPT OF OF PRIVACY NOTICE
I acknowledge that I have been offered/received a copy of the Provider's Notice of Privacy Practices with the effective date of April 28, 2003.

___________________________ has permission to obtain my medical records.

Signed Date

AUTHORIZATION TO OBTAIN MEDICAL RECORDS:
I hereby authorize Wichita Radiological Group to obtain any and all of my medical records.

Signed Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby assign and authorize for direct payment for radiological and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance.

Signed Date

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Wichita Radiological Group to release any information acquired in the course of my examination or treatment to my referring doctor and/or insurance company.

Signed Date

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

IMAGING CENTER AT CYPRESS

Date____________________

Name:____ Height__________ Weight__________
(Last Name) (First Name) (M.I.)

Birth Date_____________________ Physician's Name ____

1. Have you ever had surgery or any similar invasive procedure? Yes ☐ No ☐
   If yes, please list:
   Type:____ Date: ____________________
   Type:____ Date: ____________________

2. Have you had previous studies related to today's examination? Yes ☐ No ☐
   If yes, please list:

	Body part	Date	Facility Location
MRI			
CT/CAT Scan			
X-ray			
Ultrasound			
Nuclear Medicine			

3. Have you ever had metal removed from your eye? Yes ☐ No ☐

4. If so, have you had an MRI since? Yes ☐ No ☐

5. Are you pregnant or experiencing a late menstrual period? Yes ☐ No ☐

6. Are you breast feeding? Yes ☐ No ☐

7. Date of last menstrual period:__________________

8. Are you currently taking or have you recently taken any medication? Yes ☐ No ☐
   If yes, please list: ____

9. Do you have any drug allergies? Yes ☐ No ☐
   If yes, please list: ____

10. Have you ever had asthma, allergic reaction, respiratory disease, or other reaction to a contrast medium
    or dye used for an MRI or CT examination? Yes ☐ No ☐
    If yes, please describe: ____

11. Have you ever been diagnosed with cancer? Yes ☐ No ☐

12. Do you have diabetes, kidney problems or high blood pressure? Yes ☐ No ☐

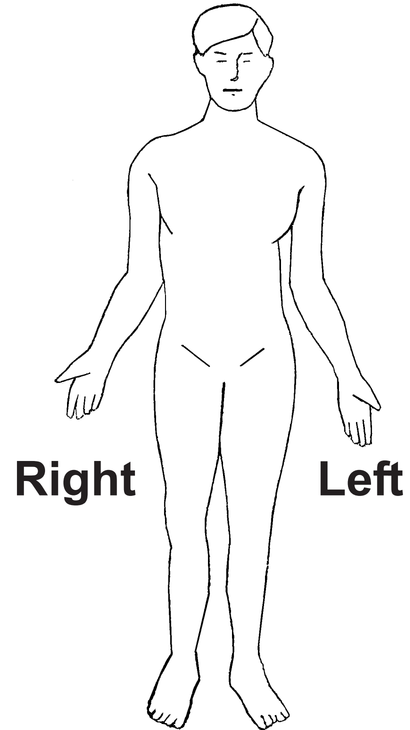
13. If yes to high blood pressure, is it controlled by medication? Yes ☐ No ☐

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

- ☐ Yes ☐ No Cardiac Pacemaker
- ☐ Yes ☐ No Implanted cardiac defibrillator
- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Carotid artery vascular clamp
- ☐ Yes ☐ No Neurostimulator
- ☐ Yes ☐ No Insulin or infusion pump
- ☐ Yes ☐ No Bone growth/fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic or ear implant
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No Artificial limb or joint
- ☐ Yes ☐ No Intravascular stents, filters or coils
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Swan-Ganz catheter
- ☐ Yes ☐ No Any implant held in place by a magnet
- ☐ Yes ☐ No Transdermal delivery system (Nitro)
- ☐ Yes ☐ No IUD or diaphragm
- ☐ Yes ☐ No Tattooed makeup (eyeliner, lips, etc.)
- ☐ Yes ☐ No Body piercing(s)
- ☐ Yes ☐ No Any metal fragments
- ☐ Yes ☐ No Internal pacing wires
- ☐ Yes ☐ No Aortic clip
- ☐ Yes ☐ No Metal or wire mesh implants
- ☐ Yes ☐ No Wire sutures or surgical staples
- ☐ Yes ☐ No Metal rods in bones
- ☐ Yes ☐ No Joint replacement ____________________
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate
- ☐ Yes ☐ No Hearing aid *(Remove before MRI)*
- ☐ Yes ☐ No Dentures *(Remove before MRI)*
- ☐ Yes ☐ No Other, please explain __________________

____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paper clips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS & EARPHONES DURING THE MRI EXAMINATION

____ Date ____________________

Signature of Person Completing Form

Form completed by: ☐ Patient ☐ Relative: ______________________________

Name & relationship to patient