	Exam Date and Time:	MRN/Jacket:	Patient Registration

Name:

Address: City, State, Zip:

Home Phone: Mobile Phone:

Email: Date of Birth:

Race: Gender: Marital Status:

SSN:

Referring Physician:

Emergency Contact Information

Name: Contact Phone:

Insurance

Primary Insurance Plan Name:

Policy #: Group #:

Secondary Insurance Plan Name:

Policy #: Group #:

Relationship to Insured

Insured Name: Relationship to Patient:

Insured DOB:

Auto Accident or Worker's Compensation Information

Is this injury due to accident? Yes ☐ No ☐ If yes, what type of Accident?

Accident Date: Accident State:

By signing below, I agree to the following for outpatient radiology care provided by

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, may use and disclose my protected health information for treatment, payment and health care operations as explained in the . Notice of Privacy Practices. I also authorize release of my protected health information to , the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?

Yes ☐ No ☐

MEDICAL RECORDS CAN BE RELEASED TO:

Name: ______________________________ Date of Birth: ___________________ Relationship to Patient: ____________________________

Financial Responsibility

With this consent, I authorize and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it may decline to provide treatment to me.

Signature: ____ **Date:** ___________________

Printed Name: ____

MRI/CT EXAMINATION QUESTIONAIRE

NAME: ______________________________ **DOB:** ______________

ARE YOU CLAUSTROPHOBIC? ______________________________

BRIEFLY DESCRIBE YOUR PAIN AND INDICATE HOW LONG YOU HAVE HAD THESE SYMPTOMS: ______________

____

____

WERE YOU INJURED? IF SO, EXPLAIN AND GIVE THE DATE: ______________________________

____

____

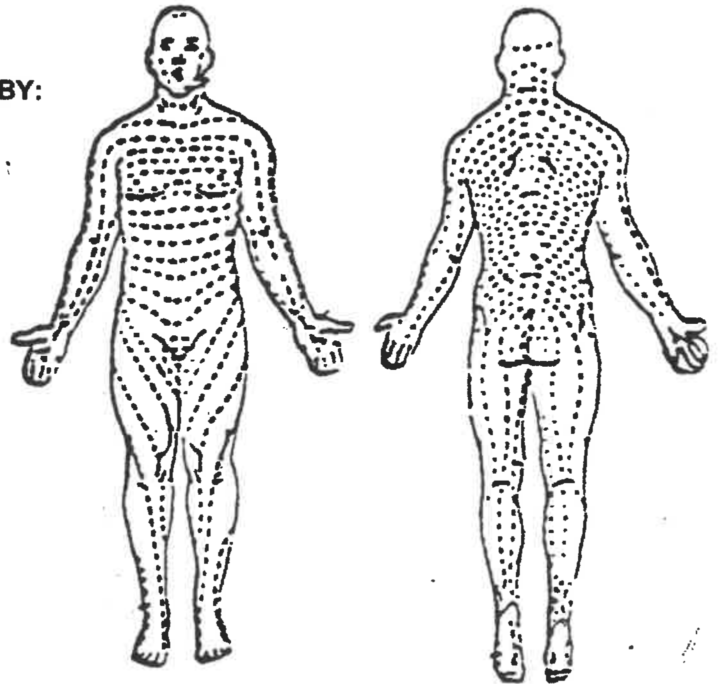
HAVE YOU HAD PRIOR SURGERY TO THIS AREA? IF SO, DESCRIBE AND GIVE THE DATE: ______________

____

____

PLEASE INDICATE THE AREAS OF YOUR SYMPTOMS BY:

P = PAIN,
T = TINGLING,
N = NUMBNESS,
W = WEAKNESS



I attest that the above information is correct and true to the best of my knowledge.

Patient Name (Please Print): ______________________________

Patient Signature: ______________________________ Date: ______________

Nebraska Health Imaging

MRI HISTORY FORM

Patient Name: ______________________

DOB: ____________ Age: ____________ Height: ____________ Current weight: ____________

Have you had a previous imaging study related to this problem? ☐ Yes ☐ No

If yes. What exam? ☐ CT ☐ MRI ☐ Ultrasound ☐ X-ray ☐ Other What Facility? ____________

PERSONAL HISTORY Please indicate if you have any of the following:

☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Cardiac Pacemaker
☐ Yes ☐ No Implanted Cardioverter defibrillator (ICD)
☐ Yes ☐ No Aneurysm Clip(s)
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Neuro or Spinal Cord Stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth / Bone Stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Implanted drug/insulin infusion device
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.)
☐ Yes ☐ No Any other implant: ____________

☐ Yes ☐ No Shunt (spinal or ventricular)
☐ Yes ☐ No Tissue expander (e.g. breast)
☐ Yes ☐ No Any type of prosthesis (limb, eye, penile, etc)
☐ Yes ☐ No Metallic Stent, filter, or coil
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Wire mesh implant Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Medication Patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Tattoo of permanent make-up
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing Aid
☐ Yes ☐ No Any metallic fragment or shavings, BB, shrapnel or foreign body (including eye injuries)

PERSONAL HISTORY

Have you ever had a previous allergic reaction to injected MRI contrast ☐ Yes ☐ No

If yes, explain: ______________________

☐ Yes ☐ No Seizure Disorder
☐ Yes ☐ No Asthma
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Allergies If yes, please specify: ____________
☐ Yes ☐ No Surgeries If yes, please specify: ____________
☐ Yes ☐ No Cancer If yes, please specify: ____________

☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Kidney Disease/ Kidney Failure
☐ Yes ☐ No Dialysis
☐ Yes ☐ No Heart or Blood Disease

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? ☐ Yes ☐ No Date of last period: ____________

ACKNOWLEDGEMENT

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious effects by receiving gadolinium based contrast agents.

Patient/ Guardian Signature: ____________ Date: ____________

Technologists Signature: ____________ Date: ____________