

MEDICAL IMAGING NORTHWEST

Miss Mrs. Ms. Mr. (circle one) Inpatient Room # _____ Patient Account # _____

Patient Name _____
Last First Middle Initial

Birthdate Month _____ Day _____ Year _____ Age _____ Female Male Home Phone # _____

Patient's Mailing Address: _____
Number Street City State Zip

Patient SS#: _____ Person Responsible for Payment _____
(Not the insurance company)

Employer of Responsible Party _____ Business Phone _____

HEALTH INSURANCE If you are making a payment today, please indicate: Cash Check Visa Mastercard

Primary Insurance Company is _____ Patient is Subscriber Spouse Dependent

Name of Subscriber _____ Subscriber's SS# _____

Address _____ Group # _____ ID# _____

Secondary Insurance Company is _____ Patient is Subscriber Spouse Dependent

Name of Subscriber _____ Subscriber's SS# _____

Address _____ Group # _____ ID# _____

WORK RELATED INJURY IF THIS VISIT IS THE RESULT OF A WORK RELATED INJURY, PLEASE COMPLETE THE FOLLOWING:

Is it possible you were injured on the job? Yes No Date of injury _____ Claim number _____

Employer at time of injury _____ Has this injury been reported to the employer Yes No

If employer is self-insured, list company _____
Name Address Phone

CLINICAL INFORMATION

Height _____ Weight _____ Are you diabetic? Yes No If so, are you taking **oral medications**? Yes No

Do you smoke? Yes No Have you smoked? Yes No Number of years _____ Number of Packs per day _____

Were you injured? Yes No If so, how and when? _____

List any previous surgery (operations) _____

If you are a female who still has a menstrual cycle, please list beginning date of last menstrual period _____

PATIENT SYMPTOMS: _____

Have you had previous x-rays **of this type**? Yes No If so, where? _____

APPOINTMENT INFORMATION

Do you have another appointment scheduled with your doctor? Yes No If yes, please provide:

_____ Date of appointment Which doctor Referring doctor

(OFFICE USE ONLY)

Screening:	Yes	No	Yes	No	Yes	No		
Wheelchair	_____	_____	Hearing Aid	_____	_____	Head/No Make-up/Hair Products	_____	_____
Pregnant	_____	_____	BB or Bullet Fragments	_____	_____	C & T Spine/No Bra	_____	_____
Will someone be with you? (Caution: NO Pacemakers Inside Building Near MRI)	_____	_____	Dentures	_____	_____	Comfortable Clothes	_____	_____
Aneurysm/Surgical Clips	_____	_____	History of Cancer	_____	_____	Watches/Loose Jewelry	_____	_____
Pacemaker/Heart Valves	_____	_____	Metal Fragment Hx Eyes/Face	_____	_____	Wallets/Valuables	_____	_____
Type: _____	_____	_____	Need Scout Films	_____	_____	Head MRI (? Braces)	_____	_____
Artificial Limbs/Joints	_____	_____	Claustrophobia	_____	_____	Driver's License	_____	_____
Insulin Pump	_____	_____	Pre-Medicated	_____	_____	15 Minutes Early	_____	_____

