PATIENT REGISTRATION FORM

****OFFICE USE ONLY****

TODAY'S DATE: _____ **MR#: _____**

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: (_____) _____-_____ **CELL PHONE#: (_____) _____-_____**

DATE OF BIRTH: _____ **SEX: ☐ MALE ☐ FEMALE**

ETHNIC GROUP:

- ___ ASIAN
- ___ AFRICAN AMERICAN
- ___ HISPANIC/LATINO
- ___ MIDDLE EASTERN
- ___ NATIVE AMERICAN
- ___ PACIFIC ISLANDER
- ___ OTHER
- ___ WHITE

RACE:

- ___ AMERICAN INDIAN
- ___ ASIAN
- ___ BLACK/AFRICAN-AMERICAN
- ___ HAWAIIAN-PACIFIC ISLANDER
- ___ WHITE
- ___ OTHER

LANGUAGE:

- ___ ARABIC
- ___ CANTONESE
- ___ ENGLISH
- ___ HEBREW
- ___ JAPANESE
- ___ KOREAN
- ___ MANDARIN
- ___ RUSSIAN
- ___ SPANISH

SOCIAL SECURITY #: _____-_____-_____

E-MAIL ADDRESS: _____

TYPE OF EXAM: _____

REASON FOR THE EXAM: _____

************************************INSURANCE INFORMATION************************************

Name of Insurance: _____ Member ID _____ Group # _____

Secondary Insurance: _____ Member ID _____ Group # _____

PRIMARY POLICY HOLDER (please check one)**: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER**

If different than the patient, please complete the following:

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

************************************EMERGENCY INFORMATION************************************

In case of emergency, please notify:

NAME: _____

RELATIONSHIP TO PATIENT: _____

TELEPHONE #: (_____) _____-_____

PATIENT'S SIGNATURE: _____ DATE: _____

MAIN STREET RADIOLOGY

MRI QUESTIONNAIRE

NAME (PLEASE PRINT) _____ DATE _____

1. DO YOU HAVE A PACEMAKER OR ANY TYPE OF CARDIAC DEVICE/STENTS?	**YES**	**NO**
2. HAVE YOU HAD ANY BRAIN SURGERY or BRAIN CLIPS?	**YES**	**NO**
3. HAVE YOU EVER HAD ANY METALLIC FOREIGN OBJECTS IN YOUR EYE?	**YES**	**NO**
4. HAVE YOU EVER WORKED WITH SHEET METAL OR ANY METAL?	**YES**	**NO**
5. DO YOU HAVE A COCHLEAR IMPLANT OR NERVE STIMULATOR?	**YES**	**NO**
6. ARE YOU ON KIDNEY DIALYSIS?	**YES**	**NO**
7. DO YOU HAVE ANY TATTOOS? IF SO WHERE? THIS INCLUDES PERMANENT MAKEUP	**YES**	**NO**

_____

8. DO YOU HAVE ANY KIDNEY DISEASE OR CONDITION?	YES	NO
9. DO YOU HAVE DIABETES?	YES	NO
10. DO YOU HAVE BREAST TISSUE EXPANDERS?	YES	NO
11. HAVE YOU HAD ANY OTHER SURGERY?	YES	NO

IF SO, WHAT KIND? _____ DATES _____

_____

12. DO YOU HAVE SHRAPNEL FROM A GUNSHOT WOUND?	YES	NO
13. ARE YOU CLAUSTROPHOBIC?	YES	NO
14. ARE YOU PREGNANT?	YES	NO
15. ARE YOU BREAST-FEEDING?	YES	NO
16. DO YOU HAVE AN IUD/DIAPHRAGM? INSULIN PUMP?	YES	NO
17. ARE YOU WEARING A TRANSDERMAL PATCH (EX: NICODERM, FENTANYL, NITRO)?	YES	NO

IF YES, WHAT KIND? _____

18. WHAT IS YOUR APPROXIMATE WEIGHT? _____ HEIGHT? _____

19. ARE YOU HAVING ANY PAIN? YES NO IF YES, WHERE? _____

20. DO YOU HAVE ANY ALLERGIES, IF SO PLEASE LIST?_____

IF YES PLEASE DESCRIBE REACTION? _____

21. WHY ARE YOU HAVING THIS MRI? _____

SYMPTOMS? LEFT OR RIGHT? _____

22. WHEN DID YOUR SYMPTOMS BEGIN? _____

23. HAVE YOU HAD ANY TRAUMA RELATED TO THE BODY PART BEING SCANNED? IF SO, PLEASE DESCRIBE. YES NO

_____

24. DO YOU HAVE A HISTORY OF CANCER? _____

IF SO, WHAT TREATMENTS HAVE YOU HAD? _____

25. HAVE YOU HAD ANY PRIOR PROSTATE BIOPSY? YES_____ NO_____ IF YES, WHEN ?_____

26. HAVE YOU HAD A PREVIOUS MRI / CT / XRAY / NUCLEAR MEDICINE STUDY / PET SCAN / ULTRASOUND?

IF SO, WHERE? _____ WHICH PART OF YOUR BODY? _____

TO ALL OF OUR PATIENTS: It is important to know if there are any metal fragments, pieces, bits, clips, devices or metal of any kind in your body. The presence of metallic items in the vital area(s) of your body may hinder the examination. You must inform us of any such possibility prior to the MRI examination.

SIGNATURE _____ DATE _____

4/3/2018

ACKNOWLEDGEMENT

I, the undersigned, acknowledge the receipt of a complete copy of Main Street Radiology's HIPAA PRIVACY NOTICE concerning the use or disclosure of my protected health information ("PHI") and consent to the release of any medical information about me (and any others for whom I can give consent to the extent permitted by law) by Main Street Radiology's health care providers and its staff to any other heath care providers involved in caring for me (or for others for whom I can give consent) to carry out diagnosis and treatment.

With your permission, we can communicate medical information to you or a designee by fax, e-mail and voicemail. Please sign and provide the appropriate information below allowing Main Street Radiology to do so on your behalf.

- ☐ Cell Phone Voicemail _____
- ☐ Work Phone _____
- ☐ Fax _____
- ☐ Unencrypted E-Mail _____

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

EMPLOYEE INITIALS_____