

Victorville Open MRI 12276 Hesperia Road Suite 6 Victorville, CA 92395-5358 Phone: (760) 843-0995

Fax: (760) 843-0975

	PATIENT INFOR	MATION FORM			
Last Name:	First Name:		Middle Name:		
MRN:	DOB:		Gender:		
Address 1:					
Address 2:					
City: Sta	ate:		Zip Code:		
Home Phone: Work Phone:	Ce	ell Phone:	Email:		
		rk Phone □ Email			
			Li Muli		
,	Preferred I		/ Others Desificateless design	TIME's / Organism	
Race: ☐ American Indian / Alaska Native ☐ Asian			Other Pacific Islander	☐ White / Caucasian	
Are you: ☐ Hispanic ☐ Not Hispanic	Referring Physici				
	RESPONSIBLE PAR	TY INFORMATION			
Last Name:	First Name:				
Patient's Relationship to Responsible Party:			Phone:		
Address 1:					
Address 2:					
City: Sta	te:		Zip Code:		
	Primary Insuran	ce Information	·		
For Medicare Patients: Are You or Your Spouse W	orking?: □ YES	□NO	If Yes, whom?		
Primary Insurance Name:			Plan Name:		
Address:					
City:	State:		Zip:		
<u> </u>	Group #:		DOB:		
Policy Holder Name:			Sex:		
Policy Holder Address:					
,	State:		Zip:		
Patient's Relationship to Policy Holder:					
	Secondary Insura				
For Medicare Patients: Are You or Your Spouse W	orking?: □ YES	□ NO	If Yes, whom?		
Primary Insurance Name:			Plan Name:		
Address:					
•	State:		Zip:		
-	Group #:		DOB:		
Policy Holder Name:			Sex:		
Policy Holder Address:	0				
•	State:		Zip:		
Patient's Relationship to Policy Holder:					
	MEDICAL INF	ORMATION			
Is this visit related to an auto accident?				□ Yes	□ No
Is this visit related to an injury sustained while at work	?			□ Yes	□ No

Patient: DOB: MRN: Date of Service:

Date of Injury:				Height:	ft	in. Wo	eight:				
SMOKING STATUS:											
☐ Current Every Day ☐	Current Some	Days □ Nev	er smoked	☐ Smoker, current status unknow	vn □ Form	er smoker [□ Unknown				
ACTIVE MEDICATIONS: ☐ None											
☐ ActoPlus Med	□F	ortamet		☐ Glyburid Met	□М	☐ Metaglip					
☐ Avandamet	☐ Glucophage			☐ Glycomet	□М	☐ Metformin					
□ Diabex	□G	Blucovance		□ Janumet	□ Pi	☐ PrandiMet					
☐ Diafomin	□ Glumetza			☐ Kombiglzexr	□ Ri	☐ Riomet (liquid form of Metformin)					
MEDICAL HISTORY: □ None											
☐ Aneurysm Clip / Coil ☐ Breast Implants			☐ Insulin Pump	□ Pa	□ Parplegic						
☐ Aneurysm Had Surgery	☐ Cancer			☐ Metal In the Body	□ Pi	☐ Previous CT Contrast Reaction					
☐ Aneurysm NO Surgery		☐ Diabetes		☐ Morphine Pump	□ Pi	☐ Previous MR Contrast Reaction					
☐ Asthma	□н	☐ Hypertension		☐ Pacemaker	□R	☐ Renal Disease					
ALLERGIES: ☐ None	•			·							
☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	□ Latex	☐ Mild	☐ Moderate	☐ Severe				
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novacaine	☐ Mild	□ Moderate	☐ Severe				
☐ Betadine (Topical Iodine)	□ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe				
☐ Contrast (Med. Imaging)	☐ Mild	☐ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	□ Moderate	☐ Severe				
□ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	□ Moderate	☐ Severe				
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	□ Moderate	☐ Severe				
□ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe				
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe				
Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes. Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomitting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconciousness. Severe allergic reaction is anaphalytic shock.											
TO OUR FEMALE PATIENTS											
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.											
Signature				Date							
Date of Last Menstrual Peri	od:/										
AUTHORIZATION & AGREEMENT											
I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.											
Signature of Patient, or Persona	al Representative			Date							

Patient: DOB: MRN: Date of Service: