



PATIENT INFORMATION			
SS#:	Last Name:	First Name:	
Middle:	DOB:		
Gender:		Marital Status:	
Address:			
City:	State:	Zip:	
Home Phone () -	Cell Phone () -	Work Phone: () -	
Employer:		Occupation:	
Employer Address:			
City:	State:	Zip:	
PRIMARY INSURANCE			
Insurance Company:	ID#:	Group#:	
SECONDARY INSURANCE			
Insurance Company:	ID#:	Group#:	

ATTENTION ALL MEDICARE PATIENTS. Please list all medical insurance policies that you have in addition to Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize INVIEW MEDICAL IMAGING to release all information necessary to secure payment from my insurance carrier(s) and Medicare (if applicable).

Signed: _____ Date: _____

PATIENT PRIVACY: Our practice is committed to securing the privacy of your health information. Accordingly, we have provided you with a copy of our practice's *Notice of Privacy Practices*. You are not required to read this notice. However, we would like your acknowledgement that you received this *Notice of Privacy Practices*.

Signed: _____ Date: _____

Free Bone Density Screening!

Risk Factors Include: All women 65+, post menopausal women (with additional risk factor), considering therapy for osteoporosis or women who are currently on hormone therapy (HRT/ERT) for prolonged periods.

YES, I'm interested in receiving a free bone density screening.

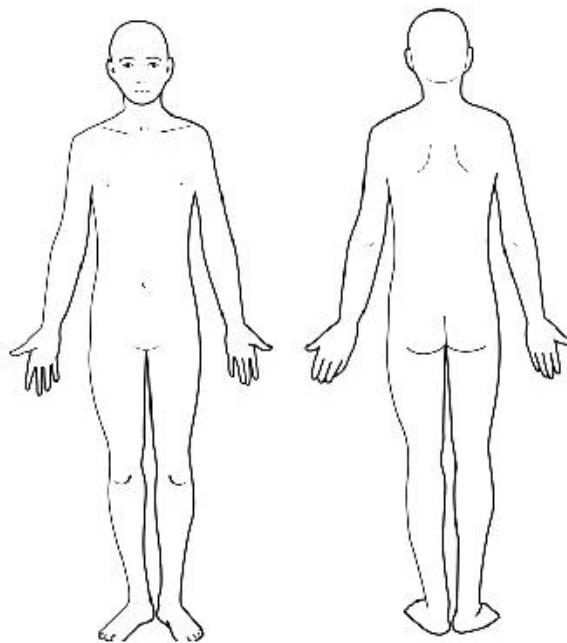
Join our mailing list. We do not sell or share our email list with any outside companies. Your email address will only be used to deliver news, discounts and announcements pertaining to InView Medical Imaging.

Email: _____

HISTORY FORM

Please describe in detail why your doctor has requested an MRI:

Please circle the body parts in which you have symptoms:



2. List other imaging studies related to today's examination (i.e. (CT Scans, Ultrasound, X-ray). Please include date and where you had the study performed.

3. Do you have Tumor: NO _____ YES _____ Location: _____
Cancer: NO _____ YES _____ Year Diagnosed: _____
High blood pressure: NO _____ YES _____
Stroke: NO _____ YES _____



MRI CONTRAST PATIENT PROFILE

PATIENT'S NAME Last	First
<input type="text"/>	<input type="text"/>

DATE OF STUDY	SEX	WEIGHT lbs.	DATE OF BIRTH	AGE
DIAGNOSIS or SYMPTOMS (Reason for this exam)				

Have you ever had X-Ray Contrast (Dye) injected before? <input type="radio"/> Yes <input type="radio"/> No	Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure LMP <input type="text"/>
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In order to perform the exam your physician has requested, you will be given an injection of contrast containing gadolinium-related products. The contrast does NOT contain iodine. The contrast media allows the radiologist to better visualize the area of study.

Gadolinium based contrast media is considered very safe. Any injection carries slight risk of harm including injury to a nerve, artery or vein, infection, or reaction to the contrast being injected. Rarely, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly a serious reaction occurs. The physicians and staff are trained to treat these reactions. Very rarely death has occurred related to contrast administration. A YES answer to any of the questions below does not mean that you will get a contrast reaction as the overwhelming majority of all patients do not.

The greatest risk is a metallic object flying through the air toward the magnet and hitting you. To reduce this risk we require that all people involved with the study remove all metal from their clothing and all metal objects from their pockets. No metal objects are allowed to be brought into the magnet room at any time. In addition, once you are in the magnet, the door to the room will be closed so that no one inadvertently walks into the magnet.

If you have any questions about the contrast agent, risks, reactions, or the procedure itself, please ask the x-ray technologist or the physician.

Did you have any of the following reactions after a prior contrast injection?

<input type="checkbox"/> Rash or hives	<input type="checkbox"/> Fainting	<input type="checkbox"/> Medical Treatment Required
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Flushing	<input type="checkbox"/> No Problems
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Other <input type="text"/>

Food Allergies: Shellfish None Other

Drug Allergies: Iodine Antibiotics Other

I UNDERSTAND AND ACCEPT THE RISKS Yes No

Patient Signature	Date
<input type="text"/>	<input type="text"/>

PROCEDURE DATA				This Section to be Completed by Technologist/Nurse			
<input type="checkbox"/> Signed consent on chart	<input type="checkbox"/> Order verified	IV Access Site Gauge Location <input type="text"/>	1st Attempt <input type="radio"/> Yes <input type="radio"/> No	Other attempted sites <input type="text"/>	Contrast Media <input type="text"/> cc's using power injection	Premedicated	
						<input type="checkbox"/> None <input type="checkbox"/> Steroids <input type="checkbox"/> Benadryl	

Patient Education

Provided To Patient Family Other Communication/Language Barriers - Explain

Complication Yes No Response Treatment

CONTRAST PATIENT PROFILE E1813 (Revised 12/16/2005)	Completed by: <input type="text"/> Tech/Nurse Signature: <input type="text"/>
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