

## Advanced Imaging of San Marcos

Patient Name:		Date Of Birth / /	Gender M F	Today's date / /2007
Mailing address:		City		State, zip code
Home phone:	Cell phone:	Work phone:		
Marital status: single married divorced widow		SSN: / /	Your weight:	
Contact person (in case of an emergency)		Phone	Please circle: Friend family member	
Responsible party (if other than patient) Name: _____ Relationship: _____		Address: _____ City, St, _____ Zip _____ Phone: _____		
Name of Insured: _____ DOB / / SSN / /		Address: _____		Phone: _____
Employer Name: _____		Address: _____		Phone: _____

Referring Physician: _____	Symptoms or reason for your test: _____ _____
Date symptoms started: / / (for insurance purposes)	_____ _____

**Have you had surgery on the area of your body we are scanning today? YES NO (please circle one)**  
**Have you had other studies on the area of your body we are scanning today?**  
**Where \_\_\_\_\_ When \_\_\_\_\_**

***FOR MRI AND MRA ONLY: PLEASE CIRCLE IF THE ANSWER IS YES: Do you have.....***

Cardiac Pacemaker	Artificial Heart Valve	Drug Infusion Device	Bullets/Shrapnel
Shunt / Stent	Prosthesis	Hearing Aids	Had metal removed from your eyes
Brain Clips	Eye Implants	Ear Implants	Personal history of cancer
Dentures, Partials	Body Piercing	Pacing Wire	Metal rods, pens, screws, etc
Neurostimulators	Claustrophobic	IUD / diaphragm	If female, possibility of pregnancy _____
Injury/ Trauma	Previous Stroke	Mass _____	date of last menstrual cycle: / /
Seizures	Visual Loss	Hypertension	or are you breastfeeding?

***Please read carefully:***

**I attest that the information above is correct to the best of my knowledge. I give consent to the examination ordered by my physician. According to the information above, I acknowledge that I have given this facility the right to file my insurance for payment of the services rendered and I agree to pay any remaining balance on the account after my insurance has paid or denied payment. I understand I must pay any coinsurance and/or deductible at time of service and that the quote for coinsurance and/or deductible is only and estimate.**

**This information may be given to San Marcos Medical Imaging for payment of services rendered for the interpretation of the requested study. I authorize release of my medical information to and from physicians, nursing facilities and/or other health care agencies to which I may be referred or transferred. I also acknowledge the Notice of Privacy Practices available in this office.**

**\*\*\*This is notification that certain services that are deemed necessary by your physician may not be reimbursed by your insurance company, including Medicare.\*\*\*\*\***

Signature of patient or guardian