

SPECIALTY **IMAGING CENTER** NORTHRIDGE

Today's Date: _____
(Fecha)

Registration Form

PATIENT INFORMATION

Last Name: _____
(Apellido)

First Name: _____
(Nombre)

M.I.: _____

Birthdate: _____
(Fecha de Nacimiento)

Age: _____
(Edad)

Sex: ☐ M ☐ F
(Sexo)

Address, Apt #: _____
(Domicilio, Numero y Calle)

City: _____
(Ciudad)

State: _____
(Estado)

Zip: _____
(Zona Postal)

Home Phone: _____
(Telefono de Casa)

Cell Phone: _____
(Telefono de Celular)

Driver's Lic. #: _____
(Numero de Licencia para Conducir)

SSN Patient: _____
(Numero de Seguro Social)

Employer: _____
(Compania de Trabajo)

Telephone: _____
(Telefono de su Trabajo)

Emp. Address: _____
(Domicilio, Numero y Calle)

City: _____
(Ciudad)

State: _____
(Estado)

Zip: _____
(Zona Postal)

INSURANCE INFORMATION

Primary Ins.: _____
(Seguiza Primaria)

Subscriber #: _____
(Numero de a seguiza)

Group #: _____
(Numero de Grupo)

Insured Name: _____
(Nombre de Su Esposo(a), o Persona Responsable)

Relationship: _____
(Relacion)

Phone: _____
(Telefono)

Insured Lic. #: _____
(Numero de Licencia para Conducir)

SSN Insured: _____
(Numero de Seguro Social)

Employer: _____
(Compania de Trabajo)

Telephone: _____
(Telefono de su Trabajo)

Emp. Address: _____
(Domicilio, Numero y Calle)

City: _____
(Ciudad)

State: _____
(Estado)

Zip: _____
(Zona Postal)

MEDICAL INFORMATION

Doctor who referred you to our office: _____
(Nombre del doctor quien lo mando)

Was there an injury? ☐ Yes ☐ No
(Fue un Herida)

Date of Injury _____
(Fecha de Herida)

Type of Injury: ☐ WORK ☐ PERSONAL
(Tipo de Herida) (Trabajo) (Personal)

SIGNATURES

I attest that the information provided on this form is true to the best of my knowledge. I understand that ALL fees are due from ALL PATIENTS as services are rendered, unless prior arrangements have been made with this office. I understand that Insurance Authorization does not guarantee payment and I am responsible for all charges. Please Return this form with your Driver's License and Insurance Card.

(Atesto que toda la informacion en esta forma es real y verdadera de acuerdo a mi conocimiento. Entiendo que todos las tarifas de los servicios son disponibles al tiempo que los servicios son realizados. Entiendo que autorizacion del seguro no garantiza el pago y que yo soy responsable por todos los cargos. Favor de regresar esta forma con su licencia de conductor y tarjeta de su seguro medico.)

 Signature of Patient

 Date



MRI SCREENING AND HISTORY

PATIENT NAME: _____ D.O.B. _____ WEIGHT: _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. DO NOT ENTER the MRI scan room if you have questions or concerns.

Have you been here before Yes ☐ No ☐ When?: _____

Do you have kidney / renal disease? (Including one kidney, renal transplant, or renal tumor) YES ☐ NO ☐

Are you on dialysis? YES ☐ NO ☐ Do you have history of severe liver disease or liver transplant? YES ☐ NO ☐

If you have any of the following items in your body, please indicate:

Cardiac Pacemaker	YES <input type="checkbox"/> NO <input type="checkbox"/>	Medication Skin Patch	YES <input type="checkbox"/> NO <input type="checkbox"/>
Brain Aneurysm Clips	YES <input type="checkbox"/> NO <input type="checkbox"/>	Tattoo or Permanent Make Up	YES <input type="checkbox"/> NO <input type="checkbox"/>
Carotid Artery Vascular Clamp	YES <input type="checkbox"/> NO <input type="checkbox"/>	Penile or Testicular Implant	YES <input type="checkbox"/> NO <input type="checkbox"/>
Infusion Pump	YES <input type="checkbox"/> NO <input type="checkbox"/>	IUD or Pessary	YES <input type="checkbox"/> NO <input type="checkbox"/>
Implanted Cardiac Defibrillator	YES <input type="checkbox"/> NO <input type="checkbox"/>	Dentures or Braces	YES <input type="checkbox"/> NO <input type="checkbox"/>
Shrapnel/Bullets/Pellets or Metallic Fragment	YES <input type="checkbox"/> NO <input type="checkbox"/>	Neurostimulator	YES <input type="checkbox"/> NO <input type="checkbox"/>
Electronic Implant, Wires or Device	YES <input type="checkbox"/> NO <input type="checkbox"/>	Heart Valve Prosthesis	YES <input type="checkbox"/> NO <input type="checkbox"/>
Eye Implants or Prosthesis	YES <input type="checkbox"/> NO <input type="checkbox"/>	Hearing Aid	YES <input type="checkbox"/> NO <input type="checkbox"/>
Shunt	YES <input type="checkbox"/> NO <input type="checkbox"/>	Cochlear Implant	YES <input type="checkbox"/> NO <input type="checkbox"/>
Intravascular Stent, Filter, Coil	YES <input type="checkbox"/> NO <input type="checkbox"/>	Metal Screws, Plates or Rods	YES <input type="checkbox"/> NO <input type="checkbox"/>
Joint Replacement	YES <input type="checkbox"/> NO <input type="checkbox"/>	Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Other <input type="checkbox"/>	

Have you possibly ever had an injury to the eye involving a metallic object fragment, shavings, or grindings? YES ☐ NO ☐
Could you be pregnant? YES ☐ NO ☐ Are you breast feeding? YES ☐ NO ☐

Are you diabetic? YES ☐ NO ☐ Do you have high blood pressure? YES ☐ NO ☐

Any known allergies? YES ☐ NO ☐ Please list: _____

Are you allergic to Gadolinium or Iodine contrast? YES ☐ NO ☐

Please describe your reaction? _____

Do you have history of cancer? YES ☐ NO ☐ Type: _____ When? _____

I have read the above information and answered to the best of my knowledge. I hereby give consent to have an MRI scan. I have directed all of the questions to my Doctor or the MRI staff.

PATIENT SIGNATURE _____ TODAY'S DATE: _____

SPECIALTY IMAGING CENTER

NORTHRIDGE

You are scheduled for an MRI of: _____

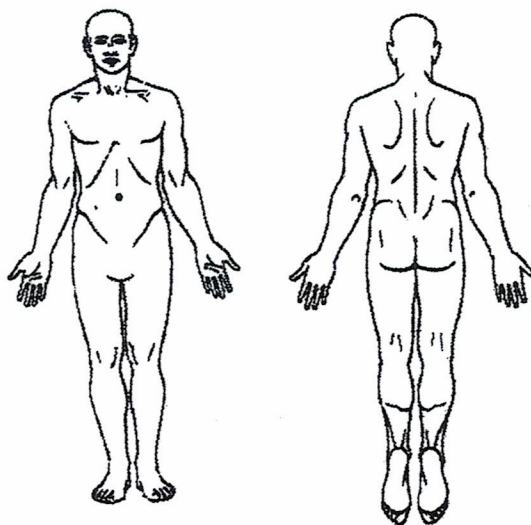
Please describe any symptoms or problems involving the area of your body being scanned today:

How long have you had your symptoms? _____

Please list any previous surgeries or fractures involving the area of your body being scanned today:

Have you had any previous studies on the same area of your body being scanned today? If so, please list the scan type, when and the facility name that performed scan.

If today's study is being done because of PAIN, NUMBNESS or WEAKNESS, please circle/shade those body areas on the diagram below:



Signature _____ Date: _____

19871 Nordhoff Street
Northridge CA 91324
(818)349-5050 (T)
(818)349-5052 (F)



**PATIENT CONSENT FORM TO USE AND DISCLOSE PROTECTED HEALTH
INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

By signing this form, you are granting consent to Northridge Specialty Imaging Center to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our "Notice of Privacy Practices" provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our "Notice of Privacy Practices" before you sign this consent and we encourage you to read it in full.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operation. We are not required by the law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Northridge Specialty Imaging Center may disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals is relevant to their involvement in your care or the payment for your care. Northridge Specialty Imaging Center also may notify a family member or another person who is responsible for your care of your location and general health condition. Please initial on the following to indicate your choice regarding such disclosures.

- I do not object my personal health information being disclosed to a family member friend, or another individual in my care.
- I object to my personal health information being disclosed to a family member friend, or another individual in my care.

Patient Name : _____ Date: _____

Signature of Patient or Patient Representative: _____