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 Cunducir) SSN Patient: ____________ (Numero de Seguro Social)

Employer: ____________ (Compañia de Trabajo) Telephone: ____________ (Telefono de su Trabajo)

Emp. Address: ____________ (Domicilio, Numero y Calle)) City: ____________ (Ciudad) State: ______ (Estado) Zip: ____________ (Zona Postal)

INSURANCE INFORMATION

Primary Ins.: ____________ (Seguanza Primaria) Subscriber #: ____________ (Numero de a siguranza) Group #: ____________ (Numero de Grupo)

Insured Name: ____________ (Nombre de Su Esposo(a), o Persona Responsible) Relationship: ____________ (Relacion) Phone: ____________ (Telefono)

Insured Lic. #: ____________ (Numero de Licencia para Cunducir) SSN Insured: ____________ (Numero de Seguro Social)

Employer: ____________ (Compañia 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 desponibles 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 lisencia 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:**

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

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 TP 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 may use and disclose this protected health information. You have a legal right to review out "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 relevant to their involvement in your care or the payment for your 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:_____________________________________