Memorial MRI and Diagnostic **Stat or Routine**

Exam / Procedure: _____ **Chart #** _____

Date of Exam: _____ **Age:** _____ **Sex:** _____ **Date of Birth:** _____

Patient's Name:_____**Referring Physician:**_____

X-Ray / IVP, CT Scan, and Ultrasound: Patient History

☐ Yes ☐ No Have you had any surgeries? If yes, explain? _____

Where? _____

☐ Yes ☐ No Do you have any pain? If yes, where is the pain at and where is it radiating to?

_____

☐ Yes ☐ No Do you or have you ever had cancer or tumor? _____

☐ Yes ☐ No Are you diabetic? Type of medication taking: _____

☐ Yes ☐ No History of kidney failure?

☐ Yes ☐ No History of heart disease?

☐ Yes ☐ No History of Seizures / Headaches / Dizziness How Long? _____

☐ Yes ☐ No History of sickle cell anemia / Blood Disorder?

☐ Yes ☐ No History of asthma? History of Hypertension ☐ YES ☐ NO

☐ Yes ☐ No History of Liver Disorder?

☐ Yes ☐ No History of unstable angina?

☐ Yes ☐ No History of recent heart attack?

Explain your medical problem in details (What is the problem? Where is the problem? How long have you had the problem?):

_____

_____

_____

Is your problem related to an injury, trauma, or auto accidents? Yes No.
If yes, date of injury? _____Please give a detailed description on how you were injured?

_____

_____

For Female Patients Only: Pregnancy Release

To the best of your knowledge are you pregnant? ☐ YES ☐ NO Date of Last Menstrual Cycle? _____

I am aware that having an X-ray or CT exam while pregnant could be harmful to an unborn baby. It is my understanding that protective shielding will be used when applicable and hereby gives my consent for Memorial MRI and Diagnostic to perform the X-Ray / CT Scan which my physician has prescribed.

Patients Initial: ***IF NOT SURE PLEASE INFORM THE FRONT DESK FOR A PREGNANCY TEST**

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Parent or Guardian)

_____

Date Signed: _____

MEMORIAL MRI & DIAGNOSTIC

Patient's Name: _____ Sex:_____ DOB: _____

SS# _____ Address: _____

City /State/ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Insurance Name: _____ ID#: _____ Group #: _____

Primary Card Holder if not Patient: _____DOB: _____

SS# _____WORKER'S COMP INFO: Employer: _____

Date of Injury: _____Address: _____ City / State/ Zip: _____

Contact Person: _____ Work #: _____ Fax #: _____

Attorney's Name: _____ Office #: _____ Fax #: _____

Treatment & Insurance Authorization

Authorization for Release of Information and Assignment of Benefits

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, tests, surgical and other medial procedures as deemed necessary by myself and the medical staff.

Authorization for Treatment

I hereby assign to the above named office, those benefits otherwise payable to me and by any third party as reimbursement of expenses and fees in connection with treatment rendered.

I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.
I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.
I certify that the information on this form given by me for payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical or related information about me, to be released to the HealthCare Finance Administration or other health care coverage entity, and information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well cared is not covered by Medicare or many other health insurance programs.

PATIENT SIGNATURE:_____Date: _____

Medical Records Authorization

I hereby authorize the release of my films and /or medical records as needed for subsequent medical care. In the eve nt of postive findings, I authorize my attending physician to release the results of my biopsy-surgery to the provider named above for their records.

I hereby request that any MEDICAL RECORDS be released to:

MEMORIAL MRI & DIAGNOSTIC
1346 Campbell Road
Houston, Texas 77055
Office #: 713-461-3399 Fax #: 713-461-1969

MEMORIAL MR & DIAGNOSTIC
1241 Campbell Road
HOUSTON, TEXAS 77055
Office #: 713-461-3399 Fax #: 713-461-1969

IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS AUTHORIZATION, PLEASE STATE RELATIONSHIP WITH PATIENT AND THE REASON PATIENT IS UNABLE TO SIGN: _____
_____

Office Use Only: Information Requesting: ☐ MRI REPORTS ☐ MRI FILMS ☐ ULTRASOUND REPORTS ☐ ULTRASOUND FILMS ☐ NUCMED FILMS ☐ NUCMED FILMS ☐ CT REPORTS ☐ CT FILMS ☐X-RAYS/FLOURO REPORTS ☐ X-RAYS/FLOURO FILMS ☐ Other Healthcare Information to the following treatment, condition, or date of treatment: