**Jacksonville Upright MRI**

Patient Information Form

Name:_____
First Middle Last

SSN:_____DOB:_____Ordering DR:_____

Hm. Phone:_____ Wk. Phone:_____Cell phone:_____

Complete Home Address:_____City:_____Zip:_____

Place of Employment:_____ Phone Number:_____

Primary Insurance_____Member ID#:_____Auth #:_____

Secondary Ins._____Member ID:_____Auth #:_____

Is your study a result of an auto accident? Yes or No
Is your study a result of a worker's compensation injury? Yes or No
Is this an open claim? Yes or No
Date of Injury/Accident?_____ State where accident occurred?_____
Insurance Company Name:_____ Phone:_____
Claim Number:_____ Adjuster Name:_____

**Assignment of Benefits:**
I hereby give authorization of payment of insurance benefits to be made directly to Jacksonville Upright MRI for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment benefits; I further agree that a photocopy of this agreement shall be as valid as the original.

**Release of Medical Records:**
I hereby give Jacksonville Upright MRI permission to request and obtain any pertinent medical reports, lab results, and x-rays from my physician or hospital/clinic should this be necessary for further evaluation.

I further give my permission to the physician and/or hospital clinic to release medical reports to Jacksonville Upright MRI.

I also give my permission to release my medical reports to my physician and/or hospital/clinic should this be necessary for further evaluation.

It is my understanding that unauthorized disclosure of this information to a third party is prohibited by state and federal statute. It I want to revoke this release, I must do so in writing and such revocation to be effective from the time of receipt.

**Notice of Privacy Practices**
I have received and read the "Notice of Privacy Practices" as provided by Jacksonville Upright MRI. This notice describes how health information about me may be used and disclosed, and how I can get access to this information.

**Authorization for Call Confirmation**
Jacksonville Upright MRI may call to confirm your appointment. In the event that we must leave a message, we may disclose your appointment date, time, and that we are calling from Jacksonville Upright MRI.

Patient Signature:_____ Date:_____

(PLEASE SEE OTHER SIDE)

# ***JACKSONVILLE UPRIGHT MRI – PATIENT INFORMATION FORM***

***DATE:_____***

***Place of Employment:_____ Phone Number:_____***

***PROBLEM LIST/PAST MEDICAL HISTORY:*** Have you ever had any of the following? Check all that apply.

| | | |
|---|---|---|
| ____Pain | ____Depression | ____Kidney/Renal Problems |
| (Body Part:_____) | ____Diabetes | ____Lung Disease(COPD, Asthma) |
| ____Anemia | ____Epilepsy | ____Osteoporosis |
| ____Anxiety | ____Headache | ____Seizures |
| ____Blood Clots | ____Heart Trouble | ____Stomach Problems |
| ____Blood Disorders | ____High Blood Pressure | ____Thyroid Problems |
| ____Cancer(type:_____) | ____High Cholesterol | ____Ulcers |

***SMOKING STATUS:***

_____Every day smoker _____Occasional smoker _____Former smoker _____Never

**Please list current medications you are taking:**

| Drug | Dosage(mg) | Number of times taken per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergies** – Do you have any drug allergies? Yes or No

| Drug | Reaction | Drug | Reaction |
|---|---|---|---|
| | | | |

Are you allergic to Latex, Iodine, or Contrast Dye? Yes or No What reaction?

_____ _____

***Race/Ethnic Data:***

___**White (Non Hispanic)**Origins of Europe, North Africa, or Middle East

___**Black or African American(Non Hispanic)**Origins of any of the black racial groups of Africa

___**Two or more races(Non Hispanic)**All persons who identify with more than one of the above races

___**Asian (Non Hispanic)**Origins of the Far East, Southeast Asia, or the Indian subcontinent

___**Hispanic or Latino** Mexican, Cuban, Puerto Rican, South or Central America, or other Spanish culture

___**Native Hawaiian or other Pacific Islander** Origins of Hawaii, Guam, Samoa, or other Pacific Islands

___**American Indian of Alaskan Native** Origins of North and South America who maintain Tribal affiliation or community

Patient Signature:_____ Date:_____