Gulf Imaging Open MRI and Digital Mammography **Date _____ Chart _____**

Patient Registration

Name _____
Last First Middle

Mailing Address _____
Street Apt #

_____
City State Zip

Phone _____ Work _____

Cell _____SSN # _____ DOB _____

Emergency contact _____

Relationship _____ Phone _____

Primary Insurance _____ secondary _____

If you ARE NOT the PRIMARY card hold (including Tri-care) we will need the following information to process your insurance. With out this information your insurance company can deny payment and the patient will be responsible for the services.

Spouse Name _____ DOB _____ SSN _____

AUTO ACCIDENTS INFORMATION

With out this information your auto insurance CAN NOT be processed and the patient will be responsible for the services.

Company **name** & **address**_____

Adjuster name _____ Phone & extension _____

Date of accident _____ Claim # _____

Release Agreement

1.) *I authorize **Gulf Imaging Open MRI** to release protected health information in the form of MRI or Digital Mammography diagnostic images to Bay Radiology and or another Florida Licensed radiologist firm; or, my referring physician for the purpose of a radiological read of the images and or other treatment.*
2.) *I authorize **Gulf Imaging Open MRI** to release information regarding my MRI/Mammo and/or my medical condition and treatment to my insurance company, physicians, attorney and/or any other health care professional involved in my medical care.*
3.) *I herby authorize **Gulf Imaging Open MRI** to obtain any medical records and/or reports from any physician, hospital or other facility. To be used for comparison, as well as my diagnostic.*
4.) *I authorize payment of benefits from my insurance coverage directly to **Gulf Imaging Open MRI.***
5.) *I understand that I am fully responsible for payment of all charges resulting from such medical treatment and that such charges are due and payable at the time of service, unless I have made other arrangements prior to this appointment.*

_____ _____

Signature **Date**

I authorize the following family/friends(excluding Doctors) to retrieve my medical records in my absence. Without their names on this list *Gulf Imaging Open MRI* WILL NOT be allowed to release any information.

Name _____ Name _____

GULF IMAGING DIGITAL MAMMOGRAPHY

SCREENING **MAMMOGRAPHIC QUESTIONNAIRE** **DIAGNOSTIC**

PATIENT'S NAME:_____ AGE:_____ DATE:_____

PREVIOUS NAME (S):_____

DOCTOR:_____ PREVIOUS MAMMOGRAM **(WHERE/WHEN)** _____

PERSONAL INFORMATION

ARE YOU TAKING HORMONES?_____ARE YOU TAKING BIRTH CONTROL?_____

HAVE YOU HAD A HYSTERECTOMY?_____COMPLETE:_____OR PARTIAL:_____

LAST MENSTRUAL PERIOD?_____# OF BIRTHS:_____AGE AT FIRST PREGNANCY?_____

PREVIOUS BREAST SURGERY: CIRCLE ONE

HAVE YOU HAD PREVIOUS BREAST SURGERY? ========== YES OR NO

IF YES, WHEN? Rt_____Lt_____Results_____

WHAT TYPE OF SURGERY? **CIRCLE ONE**

BIOPSY LUMPECTOMY MASTECTOMY BREAST REDUCTION CYST ASPIRATION

HAVE YOU HAD RADIATION ON BREAST? ========== YES OR NO

DO YOU HAVE IMPLANTS? ========== YES OR NO

CURRENT BREAST SYMPTOMS:

DO YOU HAVE A BREAST LUMP OR MASS **NOW**? ========== YES OR NO

IF YES, WHICH BREAST? RT_____ LT _____

DO YOU HAVE PAIN OR TENDERNESS **NOW**? ========== YES OR NO

IF YES, WHICH BREAST? RT_____ LT _____

DO YOU HAVE NIPPLE DISCHARGE **NOW**? ========== YES OR NO

IF YES, WHICH BREAST? RT_____ LT _____

OTHER CURRENT BREAST SYMPTOMS_____

FAMILY HISTORY OF BREAST CANCER:

NONE _____

MOTHER _____

FATHER _____

SISTER _____

DAUGHTER _____

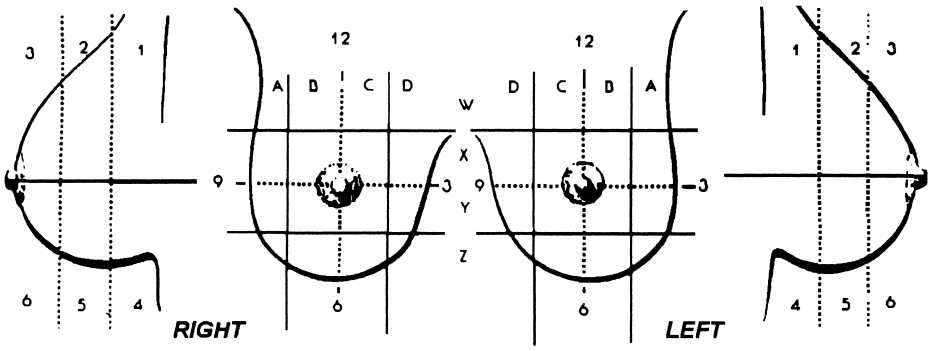
AUNT _____

GRANDMOTHER _____

COUSIN _____

OTHER _____

INDICATE
MOLES ●
SCARS ⁄⁄⁄⁄
LUMPS ✕



MEDICARE WILL ONLY PAY FOR ONE "SCREENING MAMMOGRAM" WITHIN A TWELVE (12) MONTH TIME PERIOD. **IF MEDICARE DENIES PAYMENT**, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR THE TOTAL ALLOWABLE FEE FOR SERVICES RENDERED ON THIS DATE INCLUDING ALL RADIOLOGIST FEES FOR PROFESSIONAL SERVICES.

_____ _____

SIGNATURE DATE

PATIENT NAME _____ (PLEASE PRINT)

PREVIOUS NAME _____ IF APPLICABLE (PLEASE PRINT)

BIRTH DATE _____

SOC. SEC. NUMBER _____

TODAY'S DATE _____

AUTHORIZATION FOR RELEASE OF MAMMOGRAM FILMS

I authorize and request: (Name of clinic or hospital where previous mammograms performed)

_____

_____

(Address)

To release all previous Mammograms and other Breast Imaging studies to:

Gulf Imaging Open MRI
406 West 19th Street
Panama City, FL 32405
(850) 784-0545 • FAX (850) 215-4045

I understand these films will be used for comparison with Gulf Imaging Digital Mammography mammograms and returned to sender.

_____ _____

Signature of Patient Date

AUTHORIZATION FOR RELEASE OF MAMMOGRAM FILMS FOR PERMANENT TRANSFER

I authorize and request: (Name of clinic or hospital where previous mammograms performed)

_____

_____

(Address)

To release all previous Mammograms and other Breast Imaging studies to:

Gulf Imaging Open MRI
406 West 19th Street
Panama City, FL 32405
(850) 784-0545 • FAX (850) 215-4045

I understand these films will be used for comparison with Gulf Imaging Digital Mammography mammograms and maintained for permanent record.

_____ _____

Signature of Patient Date

IF YOU HAVE NO RECORDS FOR THIS PATIENT, PLEASE FAX 850-215-4045 OR MAIL THIS AUTHORIZATION BACK TO GULF IMAGING OPEN MRI/DIGITAL MAMMOGRAPHY AT ABOVE ADDRESS.

NO RECORDS FOUND ☐

MR SCREENING FORM

NAME: _____DATE: _____WEIGHT___

1. Have you had prior surgery or an operation of any kind?
__No __Yes
If yes, please indicate the date & type of surgery:

_____

2. Have you had a prior MRI? ___No ____Yes
If yes, please list procedure, date, and facility:

_____

3. Are you allergic to any medication? ___No ____Yes
Please list:

_____

4. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium (gadolinum) or dye used for an MRI? ____No ____Yes

5. Do you have anemia or any disease that affects your blood, a history of renal (kidney) disease or seizures? ____No ____Yes

6. Have you ever had metal fragments in your eye?
_____No _____Yes

For Female Patients:

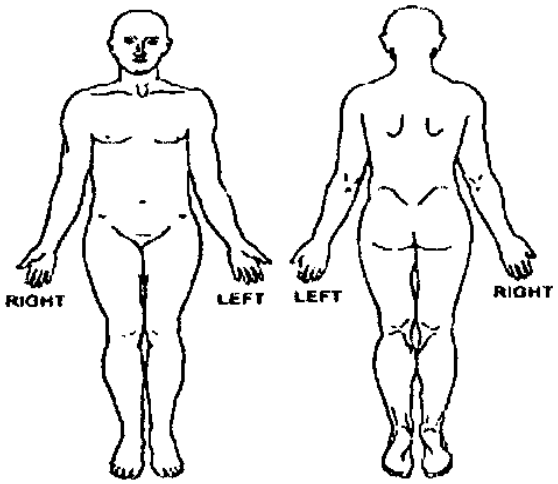
1. Are you pregnant? ____No ____Yes
2. Are you experiencing a late menstrual period?
____No ____Yes
3. Are you currently breastfeeding? _____No _____Yes

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- ❒ Yes ❒ No Aneurysm clip(s)
- ❒ Yes ❒ No Cardiac pacemaker
- ❒ Yes ❒ No Implanted cardioverter defibrillator (ICD)
- ❒ Yes ❒ No Electronic implant or device
- ❒ Yes ❒ No Magnetically-activated implant or device
- ❒ Yes ❒ No Neurostimulation system
- ❒ Yes ❒ No Spinal cord stimulator
- ❒ Yes ❒ No Internal electrodes or wires
- ❒ Yes ❒ No Bone growth/bone fusion stimulator
- ❒ Yes ❒ No Cochlear, otologic, or other ear implant
- ❒ Yes ❒ No Insulin or other infusion pump
- ❒ Yes ❒ No Implanted drug infusion device
- ❒ Yes ❒ No Any type of prosthesis (eye, penile, etc.)
- ❒ Yes ❒ No Heart valve prosthesis
- ❒ Yes ❒ No Eyelid spring or wire
- ❒ Yes ❒ No Artificial or prosthetic limb
- ❒ Yes ❒ No Metallic stent, filter, or coil
- ❒ Yes ❒ No Shunt (spinal or intraventricular)
- ❒ Yes ❒ No Vascular access port and/or catheter
- ❒ Yes ❒ No Radiation seeds or implants
- ❒ Yes ❒ No Swan-Ganz or thermodilution catheter
- ❒ Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
- ❒ Yes ❒ No Any metallic fragment or foreign body
- ❒ Yes ❒ No Wire mesh implant
- ❒ Yes ❒ No Tissue expander (e.g., breast)
- ❒ Yes ❒ No Surgical staples, clips, or metallic sutures
- ❒ Yes ❒ No Joint replacement (hip, knee, etc.)
- ❒ Yes ❒ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❒ Yes ❒ No IUD, diaphragm, or pessary
- ❒ Yes ❒ No Dentures or partial plates
- ❒ Yes ❒ No Tattoo or permanent makeup
- ❒ Yes ❒ No Body piercing jewelry
- ❒ Yes ❒ No Hearing aid
  (Remove before entering MR system room)
- ❒ Yes ❒ No Other implant _____
- ❒ Yes ❒ No Breathing problem or motion disorder
- ❒ Yes ❒ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

❒ MRI Technologist ❒ Nurse ❒ Radiologist ❒ Other _____