Star MRI of Wayne
Patient Information Form – Ultrasound

Patient Chart #: _____ Date: _____

[ ] Male[ ] Female

Patient Name: _____ Date of Birth: ___/___/____ SS#: _____
Mailing Address: _____ City: _____ State: _____Zip: _____
Phone #'s: (Home) _____ (Work) _____ (Cell) _____

Referring Physician: _____ Phone #: _____/Fax#: _____
Additional Physician: _____ Phone #: _____/Fax#: _____

Primary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the primary insurance carrier? YES NO
If NO, please fill out the following information:
Name of Primary Insurance carrier: _____ Relationship to Patient: _____
Date of Birth: ___/___/____ Primary Insurers SS#: _____ Phone #: _____

Secondary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the secondary insurance carrier? YES NO
If NO, please fill out the following information:
Name of Secondary Insurance carrier: _____Relationship to Patient: _____
Secondary Insurers Date of Birth: ___/___/____ Secondary Insurers SS#: _____ Phone #: _____

In the event of an emergency, please contact:
Name: _____ Relationship: _____ Phone #: _____

Why is your referring physician requesting that you have this exam? _____

Have you had any previous surgery to the location in which we will be scanning? YES NO
If YES, please list the type of surgery and the procedure date: _____

Have you ever been diagnosed with cancer? YES NO
If YES, please list the type and form of treatment: _____

Have you had any relevant x-rays or other testing done prior to today's exam? YES NO
If YES, when and where were the prior tests performed and what were the results? _____

When was the last time you had anything to eat or drink? _____

Have you had any barium or contrast studies in the last 72 hours? YES NO

[For Female Patients Only – Pelvic & Obstetric Ultrasounds]
When was the date of your last menstrual period? _____
Is there a possibility of pregnancy? YES NO
OB Ultrasound patients, how many weeks pregnant? _____

I attest that the above information is correct and true to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding its requested information.

Signature (Patient or Legal Guardian): _____ Date: _____