Star MRI of Wayne
Patient Information Form – X-Ray

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? _____

Is there any possibility of pregnancy? YES NO

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: _____

Do you have medical implants of ANY type? YES NO
What type of implants? _____

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? _____

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: _____