LANDMARK IMAGING
MEDICAL GROUP INC

PATIENT REGISTRATION

Name Social Security # - -
Last ***First*** ***Middle***

Address Birth Date: Cell phone ( ) Age

City St Zip Sex: M F Date of Injury

Phone ( ) - Referred by:

Accident? Yes No / Auto Work Other Employment Status: Employed Student (F/T-P/T)

Employer Occupation Work Phone ( ) -

Nearest Relative/Friend Not Living with You Phone ( ) -

Spouse Name Spouse Employed by: Phone ( ) -

Insurance Information

Medical Ins. Co. #1

Social Sec. #
Of Insured - - Policy# or Group# Relationship to patient

Insured's Name Authorization:

DOB of Insured Employer Insurance Name

Address City St Zip Phone ( ) -

Medical Ins. Co. #2

Social Sec. #
Of Insured - - Policy# or Group# Relationship to patient

Insured's Name Authorization:

DOB of Insured Employer Insurance Name

Address City St. Zip Phone ( ) -

Attorney? Yes No Attorney Name: Phone ( ) -

Auto/Work Comp Ins. (Name/Address)

Adjuster Name Phone ( ) -

I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING MEDICAL GROUP, INC** I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature ____ Date ________________________________

11620 Wilshire Blvd., Suite 100 Los Angeles, CA 90025 Phone 310.914.7336 Fax 310.914.7326
www.landmarkimaging.com

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MRI PRE-PROCEDURE SCREENING FORM

Name ____ Height__________ Weight________
Last First M.I.
Birth Date________________________ Male Female Today's Date________________________
Physician's name & address____

Briefly describe why you are having this MRI scan (clinical history) ______________________________
____

1. Have you ever had surgery or any other invasive procedures? Yes No
   If yes, please list with approximate date of the procedure:
   ____
   ____

2. Have you had any previous studies? Yes No If yes, please list below.

	Body Part	Date	Facility Location
MRI:	____________	/ /	____________
CT/Computed Tomography:	____________	/ /	____________
X-Ray:	____________	/ /	____________
Ultrasound:	____________	/ /	____________
Nuclear Medicine:	____________	/ /	____________

3. Have you ever:
   - worked as a machinist, metal worker, or in any profession or hobby grinding metal?
   - had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, or foreign body)?
   - been injured by a metallic foreign body (e.g., bullet. BB, buckshot, or shrapnel)?

   Yes No If yes, please describe:____

4. Are you pregnant, experiencing a late menstrual period, or having fertility treatments? Yes No

5. Are you breast feeding? Yes No 6. Date of last menstrual period:________/______/______

7. Are you taking oral contraceptives or receiving hormone treatment? Yes No

8. Are you currently taking or have recently taken any medication? Yes No

   If yes, please list: ____

9. Do you have medication allergies or other allergies? Yes No If yes, please list:________________________
   ____

10. Do you have anemia, diseases affecting your blood, history of kidney disease or seizures? Yes No
    If yes, please describe: ____

11. Have you ever had asthma, an allergic reaction, respiratory disease, or a reaction to a contrast medium used for an MRI or CT exam? Yes No If yes, please describe: ____

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