3202 Tower Oaks Blvd
Suite 120
Rockville, MD 20842 (US)
Phone: (301)657-2444
Fax: (301)657-2450

BETHESDA MRI

VIRGINIA MRI

611 S.Carlin Springs Road
#102
Arlington, VA 22204 (US)
Phone: (571)488-9910
Fax: (571)488-9911

PATIENT INFORMATION FORM

Last Name:	First Name:	Middle Name:
MRN: DOB:	SSN:	Gender:
Address:		
City:	State:	Zip Code:
Please check preferred contact method: ☐ Home Phone:	☐ Work Phone:	☐ Cell Phone:
☐ Email:		
Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail		
Preferred Delivery Method: ☐ Mail ☐ Electronic	Preferred Language:	Ethnicity:
Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White		

RESPONSIBLE PARTY INFORMATION

Last Name:	First Name:	Middle Name:
Relation:	Address:	
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:

EMERGENCY CONTACT INFORMATION

Name:		Relation:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:

PRIMARY INSURANCE INFORMATION

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO	If Yes, whom?	
Primary Insurance Name:		SELF PAY (notes):
Plan Name:		
Address:		
City:	State:	Zip:
Policy #:	Group #:	DOB:
Policy Holder Name:		Sex:
Policy Holder Address:		
City:	State:	Zip:
Patient's Relationship to Policy Holder:		

SECONDARY INSURANCE INFORMATION

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO	If Yes, whom?	
Primary Insurance Name:	SELF PAY (notes):	
Plan Name:		
Address:		
City:	State:	Zip:
Policy #:	Group #:	DOB:
Policy Holder Name:		Sex:
Policy Holder Address:		
City:	State:	Zip:
Patient's Relationship to Policy Holder:		

MEDICAL INFORMATION

Is this visit related to an auto accident? ☐ Yes ☐ No

Is this visit related to an injury sustained while at work? ☐ Yes ☐ No

Date of Injury: _____/_____/_____

SMOKING STATUS:

☐ Current Every Day ☐ Current Some Days ☐ Never smoked ☐ Smoker, current status unknown ☐ Former smoker ☐ Unknown

ACTIVE MEDICATIONS: ☐ NONE

☐ ActoPlus Med	☐ Fortamet	☐ Glyburid Met	☐ PrandiMet
☐ Avandamet	☐ Glucophage	☐ Janumet	☐ Riomet (liquid form of Metformin)
☐ Diabex	☐ Glucovance	☐ Metaglip	Other _____
☐ Diafomin	☐ Glumetza	☐ Metformin	

MEDICAL HISTORY: ☐ NONE

☐ Aneurysm Clip / Coil	☐ Breast Implants	☐ Metal In the Body	☐ Previous CT Contrast Reaction
☐ Aneurysm **Had Surgery**	☐ Cancer	☐ Morphine Pump	☐ Previous MR Contrast Reaction
☐ Aneurysm **NO Surgery**	☐ Diabetes	☐ Pacemaker	
☐ Asthma	☐ Insulin Pump	☐ Parplegic	Other _____

ALLERGIES: ☐ NONE

☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	☐ Latex	☐ Mild	☐ Moderate	☐ Severe
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novacaine	☐ Mild	☐ Moderate	☐ Severe
☐ Betadine (Topical Iodine)	☐ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe
☐ Contrast (Med. Imaging)	☐ Mild	☐ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	☐ Moderate	☐ Severe
☐ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	☐ Moderate	☐ Severe
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	☐ Moderate	☐ Severe
☐ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe

Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes.
Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness.
Severe allergic reaction is anaphalytic shock.

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members.

By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

_____ _____

Signature *Date*

AUTHORIZATION & AGREEMENT

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

_____ _____

Signature of Patient, or Personal Representative, for SANA SHAIKH *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US AND IS REQUIRED BY LAW. YOU HAVE A RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE.

This Notice takes effect July 15, 2007 and will remain in effect until we replace it. We are required to abide by the terms of the notice currently in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. You will be notified of any changes during your next visit at BETHESDA MRI .

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations (TPO):
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Computers are located throughout our practice. Schedules and the patient's proposed treatment are posted on the computer throughout our facility to achieve communication and high quality healthcare.
Your Authorization: In addition to our use of your information for TPO, you may give us written authorization to use your health information or to disclose it for other purposes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or information for any reason except those described in this Notice.
To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify a family member, your personal representative, or another person responsible for your care of your location, your general condition, or death. If you are present, prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We may forward a regular newsletter to our patients and prospective new patients, which describe the various services available from our practice.
Required by Law: We may use or disclose your health information when we are required to do so by law. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or e-mail).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information.) We will charge you a reasonable cost-based fee for the expenses such as copies and staff time.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than TPO, for the last 7 years, but not before July 15, 2007. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

Please describe, in your own words, your pain and symptoms including timeframe:

_____

Prior related imaging? ☐ Yes ☐ No (If yes, when and where were they performed?):

_____

Prior related surgeries? ☐ Yes ☐ No (If yes please list):

_____

Do you have any allergies? ☐ Yes ☐ No (If yes, please list):

_____

Personal history of cancer? ☐ Yes ☐ No (If yes, please explain):

_____

Are you pregnant or is there any chance you may be pregnant? ☐ Yes ☐ No

MRI QUESTIONS

Pacemaker / Pacemaker Wires	☐ Yes ☐ No	Orbital (Eye) Prosthesis	☐ Yes ☐ No	Shrapnel / Bullet	☐ Yes ☐ No
Artificial Heart Valves or Stents	☐ Yes ☐ No	Artificial Limbs	☐ Yes ☐ No	Nursing	☐ Yes ☐ No
Aneurysm Clips	☐ Yes ☐ No	Hearing Aids	☐ Yes ☐ No	Tattoo	☐ Yes ☐ No
Internal or External Devices	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Patches for Medications	☐ Yes ☐ No
Medical Infusion Pumps	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Metal Worker / Grinder / Welder	☐ Yes ☐ No
Surgical Implants (Pins, Rods, Artificial Joints)	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No		

Please explain any items you marked yes above: _____

_____

MRI CONTRAST CONSENT

Your doctor has requested an MRI scan that requires the use of an intravenous (IV) contrast agent or "dye". This agent is a substance called gadolinium and is usually given through a needle placed in a vein, artery, or joint space. Contrast material is generally considered to be quite safe; however, there are risks of which you should be aware. Any injection carries with it the risk of damage to a vein, artery, nerve, or skin, risk of infection, and risk of allergic reaction. Many patients receiving gadolinium may experience a momentary cold feeling in the area of the injection. The injection may also cause nausea or headache for some patients. On very few occasions, a patient may experience an allergic reaction to gadolinium. The most common of the reactions are sneezing, nasal congestion, hives, and temporary breathing difficulty. The most severe cases of allergic reaction (anaphylaxis) are extremely rare but may be life threatening. Our medical staff at Bethesda MRI and Virginia MRI are trained to treat such allergic reactions.

Please answer the following questions:

Have you had a prior allergic reaction to gadolinium (MRI contrast)? ☐ Yes ☐ No

Do you have kidney disease, kidney failure or are you on dialysis? ☐ Yes ☐ No

Have you had a liver transplant within the past month? ☐ Yes ☐ No

STAFF USE ONLY			
IV		LOCATION	
CONTRAST		CC AMOUNT	
TECH		LOT #	

CT QUESTIONS Have you ever received an injection during an X-Ray or CT scan? ☐ Yes ☐ No If Yes, did you experience any problems? (Please explain)

_____

Check all that apply;

☐ Asthma	☐ Sickle Cell	☐ Heart Disease	☐ Kidney Failure
☐ Diabetes	☐ Multiple Myeloma	☐ Polycythemia	☐ Pheochromocytoma
☐ Hayfever	☐ High Blood Pressure	☐ Kidney Disease	☐ Kidney Dialysis

CT CONTRAST CONSENT

Your doctor has requested a CT scan that requires the use of an intravenous (IV) contrast agent or "dye." This agent is usually given through a needle placed in a vein. Contrast materials, especially "non-ionic" contrasts, are generally considered to be safe; however, there are some risks you should be aware of. Any injection carries with it the risk of damage to a vein, artery, nerve or skin or risk of infection. Occasionally, a patient may experience an allergic reaction the contrast material. The most common of these reactions are sneezing, nasal congestion, hives and temporary breathing difficulty. The most severe allergic reactions (anaphylaxis) are very rare, but may be life threatening. Our medical staff at Bethesda MRI and Virginia MRI is trained to treat such allergic reactions. We only use "non-ionic" contrast agents, which are considered to be the safest. Most patients receiving IV contrast will experience a temporary warm or hot flushed feeling and may feel slightly nauseated for a few moments during the injection.

Your signature below indicates that the information above is accurate, you have read and understand the above information, all of your questions have been answered and you consent to the procedure(s).

_____ _____

Signature Date