WOODBRIDGE RADIOLOGY

Chart #_____ APPT BY: _____

Patient Name_____ DOB_____

Address_____ APT# _____ City_____ Zip _____

Phone #_____ SS#_____ Email: (appointment alerts)_____

Work status	☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐Student
Marital status	☐ Single ☐ Married ☐ Widowed ☐ Divorced
How were you referred to our office	☐ Referring Dr ☐ Internet ☐ Zoc Doc ☐ Returning Patient ☐ ETC._____
When is your follow up appointment with your doctor regarding this study? _____	

Employer_____ Employer's Address _____

Emergency contact person _____phone #_____

INSURANCE INFORMATION

Is this related to an accident	☐ Yes ☐No ☐ NA If yes, ☐ Auto, ☐ W.Comp. ☐ Other
Date of accident : _____	State Auto Injury occurred in: _____

Attorney Name: _____	Phone#_____
Are you treating with a Chiropractor ☐ Yes ☐ No	Name: _____Phone: _____

PRIMARY **Authorization #** _____

Name Insurance: _____	Id # _____	Group # _____
Phone # _____	Insurance Address _____	Adj Info _____
Subscriber name _____	D.O.B/ S.S.# _____	Relationship _____

SECONDARY **Authorization #** _____

Name Insurance: _____	Id # _____	Group # _____
Phone # _____	Insurance Address _____	Adj Info _____
Subscriber name _____	D.O.B/ S.S.# _____	Relationship _____

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare patients) and all other third party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand if my account is sent to collection for payment, I will incur additional charges (a minimum of 25%) on the amount sent; this applies to co payments as well. This is for today's service and any future services at Woodbridge Radiology. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

This facility will provide a locker in which you must store your personal items and valuables. Please lock these items in the area provided, and bring the key with you into the scan room for security. Woodbridge Radiology will not accept liability for any personal belongings.

I hereby authorize Woodbridge Radiology to deliver my imaging studies to the referring physician or specialist at his/her request. I understand that these studies are a permanent part of my medical record. I hereby release Woodbridge Radiology from any and all legal responsibility or liability that may arise from release of these films. I have been offered a copy of the HIPPA compliance and understand and agree to its terms.

_____ _____

Signature **Today's date**

All patients/legal guardians must REVIEW, SIGN and DATE all paperwork.

WOODBRIDGE RADIOLOGY

MRI QUESTIONNAIRE

APPOINTMENT DATE: _____ **APPT. TIME** _____ **ARRIVAL TIME:** _____
Do You Have A Follow-up Appt. with your Doctor? _____ ***When?***_____

Patient's Name _____ **DOB**_____ (**Circle)** Male/Female

Type of Scan_____ R/O_____ **Height** _____ **Weight** _____

Referring Physician _____ **Phone #**_____

SAFETY QUESTIONS	
Do you have a Pacemaker/Defibrillator	☐ YES ☐ NO ☐ N/A
Do you have aneurysm clips	☐ YES ☐ NO ☐ N/A
Have you ever had metal go into or removed from your eyes	☐ YES ☐ NO ☐ N/A
Are you a welder, sheet metal worker or grind with metal	☐ YES ☐ NO ☐ N/A
Have you ever had any ☐ BRAIN ☐ HEART ☐ EAR/EYE surgery	☐ YES ☐ NO ☐ N/A
Have you had any surgery or procedure that left any device, implant, stents, wires or stimulators in your body	☐ YES ☐ NO ☐ N/A WHERE: _____
Do you have a tissue expander implanted	☐ YES ☐ NO ☐ N/A
Do you have removable dentures or hearing aids	☐ YES ☐ NO ☐ N/A
Do you have any tattoo eyeliner	☐ YES ☐ NO ☐ N/A
Are you wearing any medicated patches	☐ YES ☐ NO ☐ N/A
Do you have any metal or mechanical devices hooked up or inside of you	☐ YES ☐ NO ☐ N/A
Are you pregnant	☐ YES ☐ NO ☐ N/A
Can you walk without assistance	☐ YES ☐ NO ☐ N/A EXPLAIN_____

CLINICAL QUESTIONS

Have you had any previous exams of the same body part? **OBTAIN REPORT**	☐ YES ☐ NO ☐ N/A Yes, Where/When: _____
Have you had SURGERY of the body part we are scanning today **If YES, what type:** _____	☐ YES ☐ NO ☐ N/A
Do you or have you ever had any type of Cancer	☐ YES ☐ NO ☐ N/A Yes, What: _____

CONTRAST QUESTIONS

****PATIENTS NEED TO DRINK AT LEAST 2 8OZ GLASSES OF WATER PRIOR TO EXAM****

Have you had MRI Contrast (Injection) before	☐ YES ☐ NO ☐ N/A Yes, please list any allergic occurrence: _____
Have you been diagnosed with Kidney disease or Kidney failure	☐ YES ☐ NO ☐ N/A
Are you on Dialysis (If so Patient MUST schedule Dialysis after Scan	☐ YES ☐ NO ☐ N/A
Are you Diabetic	☐ YES ☐ NO ☐ N/A

****Any patient with diabetes, kidney failures or over 60 must have blood work. (Labs: BUN, GFR, Creatinine)****

I have reviewed the above information provided in the telephone screening, and it is correct. I hereby give permission to North Dover Radiology to perform this MRI exam.

Patient/Guardian Signature: _____ **Date:** _____

Attachments: ☐ Prior Exam ☐ Blood work ☐ Script

Front Desk Only: Date: _____ **☐ CONFIRMED ☐ LEFT MESSAGE ☐ NO ANSWER**

For Contrast studies: ☐ **instructed patient to drink water**

WOODBRIDGE RADIOLOGY

3T MRI • 1.2T Open MRI • Low Dose CT • Ultrasound • Digital X-Ray

CLINICAL QUESTIONNAIRE

Name:_____ Date:_____

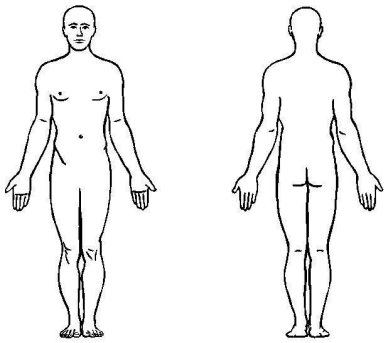
Allergies: _____

1. Why has your doctor sent you for this test? Did she/he give you a specific diagnosis?
   _____
   _____
   _____
2. Please describe what specific complaints/symptoms have been most bothersome to you?
   _____
   _____
   _____
3. How long have you had these complaints/symptoms? _____
4. Did these complaints/symptoms come on suddenly or gradually? _____
5. These complaints/symptoms have:
   _____improved _____remained the same _____worsened
6. Have you had any previous surgery related to today's exam? ____Yes ____No
   (If Yes, type and date: _____)
7. Have you had any prior tests related to today's exam, If so what were the results of the test?_____
8. Do you have any history of any cancer? ____Yes ____No
9. Do you have a history of smoking? ____Yes ____No

FEMALE PATIENTS:

1. Are you pregnant? ____Yes ____No ____ N/A
2. Date of Last Menstrual Period_____

Circle region of pain:



Patient Signature:_____ Date:_____

530 Green Street
Iselin, NJ 08830

PH# (732) 326-1515
FX# (732) 326-1522

WOODBRIDGE
RADIOLOGY

530 Green Street
Iselin, N.J. 08830
(732) 326-1515

PATIENT NAME:_____

DOB:_____/_____/_____ **PATIENT SOCIAL SECURITY #:**____-____-_____

REVIEW OF OUTSIDE FILMS POLICY:

Please make available to the front office any prior imaging films, CD's, and reports at the time of your appointment. This pertains solely to any exams preformed at any outside facilities other than Woodbridge Radiology. Please be advised that if you fail to bring your prior exam at the time of your appointment there will be a $100.00 "Review of Outside Film" charge for any comparison performed after your original appointment date.

DISC AND FILM RELEASE:

I hereby release Woodbridge Radiology located at 530 Green Street, Iselin, NJ from any and all legal responsibility or liability that may arise from release of records. For any additional disc or films a fee will be charged. The fee for a disc will be $25.00 and films will cost $75.00.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby request you to release my medical records to/from Woodbridge Radiology. Please fax all records to 732-326-1522.

Name of Referring Doctor or Organization:_____
Ph#:_____ FX#:_____

X:_____
SIGNATURE OF PATIENT OR REPRESENTATIVE:
Date:_____/_____/____