MUNSTER
OPEN MRI & IMAGING

Patient Registration

X-Ray | Please print clearly or fill in on your device

PATIENT INFORMATION

Last name | First name | M.I. | Date of birth (MM/DD/YYYY)

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street address

City | State | ZIP code

Cell phone | Home phone | Email

Social Security # | Referring physician

INSURANCE

Primary insurance | Member ID | Group #

Policy holder name | Policy holder date of birth | Relationship to patient

EMERGENCY CONTACT

Name | Relationship | Phone

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Munster Open MRI & Imaging. I understand that I am responsible for any charges not covered by my insurance. I also authorize the release of any medical information needed to process my insurance claims.

Patient or guardian signature | Date

MUNSTER OPEN MRI & IMAGING

Patient Questionnaire

X-Ray

ABOUT YOUR EXAM

Exam being performed

Height

Weight

Please describe your symptoms

How and when did this happen?

HEALTH HISTORY

Surgery in the area being scanned	☐ Yes	☐ No	
Cancer or tumor	☐ Yes	☐ No	
Chemotherapy or radiation therapy	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No	
Lung problems	☐ Yes	☐ No	
Heart or blood pressure problems	☐ Yes	☐ No	
Seizures	☐ Yes	☐ No	
Kidney failure or dialysis	☐ Yes	☐ No	
Are you, or could you be, pregnant?	☐ Yes	☐ No	☐ N/A

If you answered yes to any of the above, please explain

First day of last menstrual period

Have you had a prior CT, MRI, ultrasound or X-ray of this area? ☐ Yes ☐ No

If yes, when and where?

How did you hear about us? ☐ Physician ☐ Family ☐ Friend ☐ Online ☐ Other

Patient or guardian signature

Date

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Privacy Practices Acknowledgment

Health Insurance Portability and Accountability Act (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in my care.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have been offered the Notice of Privacy Practices, and I understand that I may contact Munster Open MRI & Imaging at any time to request a current copy. The Notice is also available at munsterimaging.com/privacy.html.

I understand that I may request in writing how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations by Munster Open MRI & Imaging.

Patient name (print)

Date of birth

Patient or guardian signature

Date

If signed by a representative, name and relationship to patient