

DATE _____

**OPEN AIRE MRI * FORT SMITH
PATIENT INFORMATION**

PATIENT'S NAME _____
FIRST MIDDLE LAST

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

SEX _____ DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

PLACE OF EMPLOYMENT _____ PHONE _____

EMPLOYER ADDRESS _____

CITY _____

SPOUSES NAME _____ DAY PHONE _____

GUARANTOR _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE _____

SPOUSE/GUARANTOR SOCIAL SECURITY NO. _____



Open Air MRI - Ft Smith

5701 Euper Lane, Suite B
Fort Smith, AR 72903
(479) 452.3810 phone
(479) 452.3444 fax
(877) 652.3810 toll free

MRI Patient Questionnaire

Date: _____ / _____ / _____ Name: _____

DOB: _____ / _____ / _____ Age: _____ Sex: M F

Height: _____ ' _____ " Weight: _____

Ordering Doctor: _____ Phone Number: _____

MRI Exam: _____

Medical History or Symptoms: _____

Previous Surgery on area of exam: Yes No

Any recent X-Rays, CT, MRI on area of exam: Yes No

Any cancer history yourself: Yes No

Pacemaker Yes No

Any Heart Surgeries Yes No

Neurostimulator Yes No

Intracranial Clips Yes No

Ear Implants Yes No

Hearing Aid Yes No

Head/Neck Surgery Yes No

Metal in Eyes (Welding) Yes No

Gunshot Wounds Yes No

Blood Filter Yes No

Insulin Pump Yes No

Dentures Yes No

Orthopedic Surgeries Yes No

Presently Pregnant Yes No

Diabetic Yes No

High Blood Pressure Yes No

To my knowledge the above statements are true and correct. I hereby consent to the MRI examination as ordered by my doctor.

Patient's Signature

Date

Witness

THE FOLLOWING WILL HAVE TO BE REMOVED PRIOR TO THE EXAMINATION:

ATM/CREDIT/BANK CARDS, BARRETTES OR HAIRPINS, COINS, HEARING AIDS, JEWELRY, KEYS, METAL HOOK BRAS, METAL ZIPPERS, PENS, PURSES, POCKET KNIVES, WALLETS, WATCHES, OR ANY OTHER METAL OBJECTS.

FOR YOUR CONVENIENCE, WE HAVE LOCK BOXES TO PROVIDE YOU WITH A SECURE PLACE TO LEAVE YOUR BELONGINGS.