South Miami OPEN MRI

88 NE 168 ST NORTH MIAMI BEACH, FL 33162
Phone: (305)665-4674 Fax: (305)509-5404
Email: frontdesk@smomri.com

APPOINTMENT: DATE:_____ TIME:_____

PATIENT NAME: _____ D.O.B. _____ M_____ F_____

Address: _____ City:_____ State: _____ Zip: _____

Phone #: Home: _____ Cell:_____ Work: _____

PHYSICIAN NAME: _____ Ph#: _____ Fx #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: _____ Ph#: _____ Ext. _____

Policy No. _____ Claim No. _____ Adjuster:_____

Address: _____ City: _____ State: _____ Zip: _____

INSURED'S NAME: _____ Relationship to Patient: . _____

SECONDARY INSURANCE: _____ Ph #: _____ Ext. _____

Policy No. _____ Group No. _____ Claim No. _____

DATE OF ACCIDENT: _____ ☐ Auto ☐ Worker's Comp. ☐ Slip & Fall ☐ Other:_____

ATTORNEY'S NAME: _____ Ph #: _____ Fax #: _____

Address: _____ City:_____ State: _____ Zip: _____

Contact: _____

MRI ☐ Without ☐ With & Without Contast (All contrast studies----Lab work required)

Head
- ☐ Brain
- ☐ IAC's
- ☐ Orbit
- ☐ Pituitary
- ☐ Soft Tissue Neck

Body
- ☐ Adrenals
- ☐ Abdomen
- ☐ Pelvis
- ☐ Kidney
- ☐ Liver
- ☐ Pancreas
- ☐ Chest

Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum
- ☐ Coccyx

Upper Extremities

☐ Shoulder	☐ L	☐ R
☐ Elbow	☐ L	☐ R
☐ Wrist	☐ L	☐ R
☐ Hand	☐ L	☐ R
☐ TMJ	☐ L	☐ R
☐ Long Bones	☐ L	☐ R

☐ Specify:_____

Lower Extremities

☐ Ankle	☐ L	☐ R
☐ Foot	☐ L	☐ R
☐ Knee	☐ L	☐ R
☐ Hip	☐ L	☐ R
☐ Long Bones	☐ L	☐ R

☐ Specify: _____

MRA ☐ Head ☐ Neck

DIGITAL X-RAYS

☐ Bone Age
- ☐ Cervical Spine
- ☐ Lumbar Spine
- ☐ Thoracic Spine
- ☐ Sacrum
- ☐ Coccyx
- ☐ Bone Age
- ☐ Chest
- ☐ Facial Bones
- ☐ KUB
- ☐ Nasal Bones
- ☐ Paranasal Sinuses
- ☐ Pelvis
- ☐ Skull
- ☐ Sternum
- ☐ Other: _____

☐ Ankle	☐ L	☐ R
☐ Clavicle	☐ L	☐ R
☐ Elbow	☐ L	☐ R
☐ Femur	☐ L	☐ R
☐ Foot	☐ L	☐ R
☐ Hand	☐ L	☐ R
☐ Hip	☐ L	☐ R
☐ Humerus	☐ L	☐ R
☐ Knee	☐ L	☐ R
☐ Radius/Ulna	☐ L	☐ R
☐ Ribs	☐ L	☐ R
☐ Shoulder	☐ L	☐ R
☐ Tibia/Fibula	☐ L	☐ R
☐ Wrist	☐ L	☐ R

CT SCAN ☐ With ☐ With/Without

(All contrast studies----Lab work required)

HEAD & BRAIN
- ☐ Brain
- ☐ IAC's
- ☐ Skull
- ☐ Sinus
- ☐ Orbits
- ☐ Facial Bones
- ☐ Neck

BODY
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis

SPINE
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

EXTREMETIES

☐ Upper	☐ L	☐ R
☐ Lower	☐ L	☐ R

☐ Specify area:_____

DIAGNOSIS: CODES (ICD 9/10) : _____ Treatment Starting Date: _____

Physician's Signature: _____ UPIN Number: _____

☐ Call for Stat **☐ CD Needed** **☐ Transportation**

IMPORTANT MEDICAL INFORMATION

If you have metallic implants, cardiac pacemaker, brain aneurysm clips, a history of being exposed to foreign metallic bodies in the eyes, or if you are (or may be) pregnant PLEASE NOTIFY THE MEDICAL PERSONNEL PRIOR TO YOUR APPOINTMENT VERIFICATION.