



**TALLAHASSEE ORTHOPEDIC CLINIC
TALLAHASSEE SPORTS MEDICINE
MRI DEPARTMENT**

3334 CAPITAL MEDICAL BOULEVARD, SUITE 700
TALLAHASSEE, FL 32308
(850) 219-1940 • FAX (850) 219-1888

PATIENT INFORMATION

PATIENT

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth _____ Age _____ Social Security # _____

Phone: _____ Occupation: _____ (If Student: Full or Part)

Sex: M F Marital Status: Married Single Divorced Widowed

Employer: _____

Address: _____

Describe your medical problem: _____

Referring Physician: _____

Name of nearest living relative/relation: _____ Phone #: _____

Right Discomfort **IMPORTANT:** Date of onset or accident: ____ / ____ / ____
 Left Injury If injury: Work Related Auto-Accident

INSURANCE

PRIMARY INSURANCE CARRIER

SECONDARY INSURANCE CARRIER

Name: _____

Name: _____

Address: _____

Address: _____

Policy #: _____

Policy #: _____

Insured's Name: _____

Insured's Name: _____

DOB: ____ / ____ / ____

DOB: ____ / ____ / ____

Group #: _____

Group #: _____

Additional Carrier Information: _____

This disclosure form is provided pursuant to and in compliance with Statute 455.25(1), 1992.

Tallahassee Orthopedic Clinic, P.A., 3334 Capital Medical Boulevard, Suite 400, Tallahassee, Florida 32308, wholly owns the Magnetic Resonance Imaging system (MRI) for which you may be referred.

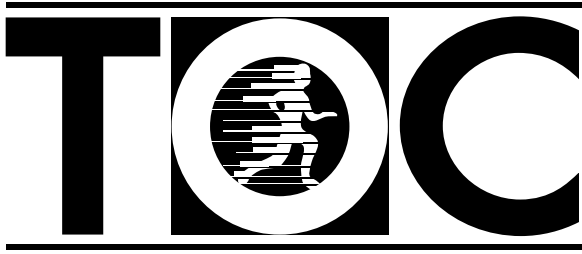
You are not required to obtain items or services but may obtain items or services from the provider or supplier of your choice.

Alternate sources of the items or services for which you may be referred to on Magnetic Resonance Imaging include:

- | | |
|--|--|
| <p>1. Open MRI of Tallahassee, LLC
2901 Kerry Forest Parkway
Tallahassee, Florida 32309</p> <p>2. Tallahassee Neurological Clinic
Open MRI
2824-1 Mahan Drive
Tallahassee, Florida 32308</p> | <p>3. Tallahassee Diagnostic Imaging
1623 Medical Drive
Tallahassee, FL 32308</p> <p>4. Stand Up MRI
2332 Capital Circle NE
Tallahassee, Florida 32308</p> |
|--|--|

I acknowledge that I have read and understand the foregoing disclosure.

(08/2009) FMI Patient Signature: _____ Date: _____



Tallahassee Orthopedic Clinic MRI Department

3334 Capital Medical Blvd., Suite 700
Tallahassee, FL 32308
(850) 219-1940

F M

Print Name _____

MRI Screening Form for Patients

Date: _____ / _____ / _____ Time: _____

Have you ever had prior surgery or an operation? Yes No

If "Yes", please indicate the date and type of surgery:

Date: _____ Type of surgery: _____

Have you had a prior MRI Study? Yes No

Have you experienced any problem related to a previous MRI exam? Yes No

If "Yes", please explain: _____

Have you had an injury to the eye involving a metallic object or fragment? Yes No

If "Yes", please explain: _____

Have you ever been injured by a metallic object (bullet, shrapnel, etc.)? Yes No

If "Yes", please explain: _____

Are you currently taking any medication or drug? (*Only list narcotics.*) Yes No

If "Yes", please explain: _____

Do you have a history of asthma, allergic reaction, respiratory disease,
or reaction to a contrast agent used for MRI or CT or X-Ray examinations? Yes No

Do you have anemia or any disease that effects your blood, a history of kidney disease, or seizures? Yes No

If "Yes", please explain: _____

FOR FEMALE PATIENTS:

Are you pregnant or experiencing a late menstrual period? Yes No

Are you currently breastfeeding? Yes No

Do you have any sort of patch you are wearing, such as a nicotine or nitro patch? Yes No

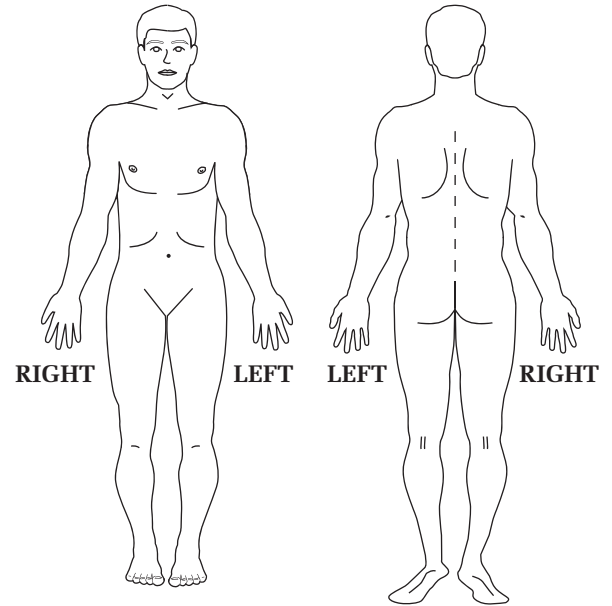


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac Pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wire
- Yes No Bone growth / bone fusion stimulator
- Yes No Cochlear, audiologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch – any type
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g. breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone / joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Denture or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other Implant: _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia
- Yes No Have you done welding or grinding?

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, denture, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge, I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: ____ / ____ / ____

Form Completed By Patient Relative Nurse (Print Name): _____
(Relationship to Patient): _____

Form Information
Reviewed By (Print Name): _____ (Signature): _____