INFO@JERSEYADVANCEDMRI.COM
JERSEYADVANCEDMRI.COM

TEL: (732)901-6745
FAX: (732)901-7550

1 KATHLEEN DRIVE, SUITE 4
JACKSON, NEW JERSEY 08527

#_____

Basic Information

Last Name: _____ **First Name:** _____ **M.I.** _____

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

Home Phone: _____ **Cell Phone** _____**Work Phone:**_____

Date of Birth: _____ **Social Security #:** _____ **Email:**_____

Employer: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Referring Dr.: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Weight:_____ **How did you hear about us:** _____

Health Insurance

Insurance Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Insured (If different from patient): _____

Group #: _____ **ID#:** _____ **Precert #:** _____

Relationship to Patient: _____ **Date of Birth:** _____

Accident Information

Please Indicate what type of accident: ☐**Auto Accident** ☐**Worker's Compensation** ☐**Other:** _____

Name of Insurance Company: _____**Address:** _____

Claim#: _____ **Policy #:** _____ **Precert#:** _____

Adjuster: _____ **Phone:** _____ **Ext:** _____

Name of Insured: _____ **Relationship to Patient:** _____

Attorney Information

Firm Name: _____

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

Telephone #: _____

JERSEY ADVANCED MRI
& Diagnostic Center

Name: _____ **Date:**_____

Please check if you have any of these items in your body:

□ Cardiac Pacemaker
□ Brain Clips
□ Aortic Clips
□ Carotid Clips
□ Neuro-stimulators (Tens-units)
□ Heart Valve
□ Insulin Pump
□ Electrodes
□ Hearing Aids or Implants
□ IUD
□ Shunts
□ Joint Replacements
□ Metal Plates, pins, screws, nails, clips, rods
□ Harrington Rod
□ Bone or Joint Pins
□ Tattooed Eyeliner
□ Prosthesis
□ Metal Mesh
□ Wire Sutures
□ Shrapnel
□ Dentures
□ Other: _____
_____

History of surgery: _____

Females only: Is there any chance of pregnancy? Yes____ No ____
Date of last period: _____

REMEMBER

Please empty pockets before entering scan room!

Please check personal belongings before leaving the facility. We are NOT responsible for any missing items after you have left the facility.

Please do NOT enter scan room with any metal or electronic items!

I certify that I have entirely read, filled out and understood this form. I will not hold any person or institution responsible for any possible omission.

X_____ Date: _____

I request that payment of authorized benefits be made directly to the professional corporation named above. I further authorize you to release any information about me needed to determine these benefits or to produce payment for these services. I fully understand that I am solely responsible for all charges incurred. If said charges are not paid, I am responsible for payment in full at that time. I further understand that I will be responsible for any additional charges such as interest, court costs, and attorney fees, should they become necessary for the collection of these services. A photo static copy of this authorization shall be considered as effective and notes as the original.

X_____ Date: _____

JERSEY ADVANCED MRI
& Diagnostic Center

Patient's Name: _____ Date: _____

Referring Dr: _____ Date of Birth: _____

BODY / OTHER		***EXTREMITIES***	
ORBITS/ SINUS		LT- HIP	
FACE		RT- HIP	
NECK		LT- KNEE	
BRAIN W - W/OUT CONTRAST		RT- KNEE	
BRAIN- ADD'L STUDY W/CONTRAST		LT- ANKLE	
ABDOMEN W – W/OUT CONTRAST		RT- ANKLE	
CERVICAL SPINE W/OUT CONTRAST		LT- FOOT	
CERVICAL SPINE W/CONTRAST		RT- FOOT	
THORACIC SPINE W/OUT CONTRAST		LT- SHLDR	
THORACIC SPINE W/CONTRAST		RT- SHLDR	
LUMBAR SPINE W/OUT CONTRAST		LT- ELBOW	
LUMBAR SPINE W/CONTRAST		RT- ELBOW	
PELVIS W/OUT CONTRAST		LT- WRIST	
PELVIS W/CONTRAST		RT- WRIST	
UPPER EXT. NON-JOINT W/O CONTRAST		LT- HAND	
UPPER EXT. NON-JOINT W/CONTRAST		RT- HAND	
UPPER EXT. NON-JOINT W/WO CONT.		RT- LOWER LEG	
UPPER EXT. JOINT W/OUT CONTRAST		LT- LOWER LEG	
UPPER EXT. JOINT W/CONTRAST		RT- FOREARM	
UPPER EXT. JOINT W/W OUT CONT.		LT- FOREARM	
LOWER EXT. NON-JOINT W/O CONT.			
LOWER EXT. NON-JOINT W/CONTRAST			
LOWER EXT. NON-JOINT W/WO CONT.			
LOWER EXT. JOINT W/OUT CONTRAST			
LOWER EXT. JOINT W/CONTRAST			
LOWER EXT. JOINT W/WO CONT.			

X_____ _____

Patient Signature **MRI Tech Initials**

JERSEY ADVANCED MRI
& Diagnostic Center

To Whom It May Concern:

I request that all payments of authorized Medicare benefits be made either to me or on my behalf to JERSEY ADVANCED MRI or DR. SIDDARTH PRAKASH for any services furnished by me by physician or supplier. I authorized any holder of medical information about me to release to centers for Medicare and Medicaid services (CMS) and its agents any information needed to determine these benefits payable to related services.

X_____ _____

Patient's Signature **Date**

<u>For Minors</u>:

X_____ _____

Parent's Signature **Date**