JERSEY ADVANCED MRI
& Diagnostic Center

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TEL: (201)552-9464
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2127 KENNEDY BOULEVARD
NORTH BERGEN, NEW JERSEY 07047

#_____

Basic Information

Last Name: _____ **First Name:** _____ **M.I.** _____
(Apellido) (Nombre)
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
(Direccion) (Ciudad) (Estado) (Codigo Postal)
Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____
(Telefono de su casa) (Telefono Celular) (Telefono del trabajo)
Date of Birth: _____ **Social Security #:** _____**Email:** _____
(Fecha Nacimiento) (# Seguro Social) (Correo electronico)
Employer: _____ **Address:** _____
(Trabajo) (Direccion del Trabajo)
City: _____ **State:** _____ **Zip:** _____
(Cuidad del Trabajo) (Estado) (Codigo Postal)
Referring Dr.: _____ **Address:** _____
(Medico De Referencia) (Direccion del Doctor)
City: _____ **State:** _____ **Zip:** _____
(Cuidad del Doctor) (Estado) (Codigo Postal)

Health Insurance

Insurance Name: _____ **Address:** _____
(Nombre Del Seguro) (Direccion del Seguro)
City: _____ **State:** _____ **Zip:** _____
(Ciudad) (Estado) (Codigo Postal)
Insured (If different from patient): _____
(Nombre del Asegurado, si diferente de Paciente)
Group #: _____ **ID#:** _____ **Precert #:** _____
(# de Grupo) (# de Poliza) (# de Depto de Authorizacion)
Relationship to Patient: _____ **Date of Birth:** _____
(Relacion al Paciente) (Fecha Nacimiento)

Accident Information

Please Indicate what type of accident: ☐**Auto Accident** ☐**Worker's Compensation** ☐**Other:** _____
(Por favor indique que tipo de accidente) (Carro) (Trabajo) (Otro)
Name of Insurance Company: _____**Address:** _____
(Nombre del Seguro de Accidente) (Direccion del Seguro)
Claim#: _____ **Policy #:** _____ **Precert#:** _____
(# de Reclamo) (# de Poliza) (# de Depto de Authorizacion)
Adjuster: _____ **Phone:** _____ **Ext:** _____
(Ajustador) (# del Ajustador) (Extencion)
Name of Insured: _____ **Relationship to Patient:** _____
(Nombre del Asegurado) (Relacion al Paciente)

Attorney Information

Firm Name: _____
(Nombre del Abogado)
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
(Direccion) (Ciudad) (Estado) (Codigo Postal)
Telephone #: _____
(# de Abogado)

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

□ Cardiac Pacemaker
□ Brain Clips
□ Aortic Clips
□ Carotid Clips
□ Neurostimulators (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
□ Shrapnal
□ 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: _____

Patient's Name: _____ Date: _____

Referring Dr: _____ Date of Birth: _____

70336	TEMPOROMANDIBULAR JOINTS		**EXTREMITIES**
70540	ORBITS/ SINUS		LT- HIP
70541	FACE		RT- HIP
70542	NECK		LT- KNEE
70551	BRAIN		RT- KNEE
70552	BRAIN- ADD'L STUDY W/CONTRAST		LT- ANKLE
71555	CHEST		RT- ANKLE
72141	CERVICAL SPINE NO CONTRAST		LT- FOOT
72142	CERVICAL SPINE W/CONTRAST		RT- FOOT
72146	THORACIC SPINE NO CONTRAST		LT- SHLDR
74147	THORACIC SPINE W/CONTRAST		RT- SHLDR
72148	LUMBAR SPINE NO CONTRAST		LT- ELBOW
72149	LUMBAR SPINE W/CONTRAST		RT- ELBOW
72195	PELVIS		LT- WRIST
73218	UPPER EXT. NON-JOINT NO CONTRAST		RT- WRIST
73219	UPPER EXT. NON-JOINT W/CONTRAST		LT- HAND
73220	UPPER EXT. NON-JOINT W/WOC		RT- HAND
73221	UPPER EXT. JOINT NO CONTRAST		RT- LOWER LEG
73222	UPPER EXT. JOINT W/CONTRAST		LT- LOWER LEG
73223	UPPER EXT. JOINT W/WOC		RT- FOREARM
73718	LOWER EXT. NON-JOINT NO CONTRAST		LT- FOREARM
73719	LOWER EXT. NON-JOINT W/CONTRAST		
73720	LOWER EXT. NON-JOINT W/WOC		
73721	LOWER EXT. JOINT NO CONTRAST		
73722	LOWER EXT. JOINT W/CONTRAST		
73723	LOWER EXT. JOINT W/WOC		

X_____ _____

Patient Signature **MRI Tech Initials**

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To Whom It May Concern:

I requested that payment 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**

For Minors:

X_____ _____

Parent's Signature **Date**