



## HURON VALLEY SINAI HOSPITAL – MRI SCHEDULING

APPT. DATE	APPT TIME	AM	DATE APPT. MADE _____	
		PM	BY WHOM: PATIENT _____ DR. _____	
PATIENT NAME		MALE	HOME PHONE:	
		FEMALE	WORK PHONE:	
DATE OF BIRTH	SS#	PRE-REG #		
ADDRESS		CITY/STATE	ZIPCODE	COUNTY
TYPE OF MRI:	PAYABLE DX:	PRIOR CT/MR IF YES BRING FILMS		
OPEN HEART SURGERY: Y N	HEART VALVE REPLACEMENT: Y N	OUTPATIENT	INPATIENT	ED
PACEMAKER: Y N	HX OF METAL IN EYES OR HX OF WELDING/GRINDING/ OR DRILLING OF METALS Y N	REASON FOR EXAM/PERTINENT HISTORY:		
PATIENTS WEIGHT _____				
ORDERING PHYSICIAN / PHONE AND SPECIALITY:				
<b>PRIMARY INSURANCE TYPE:</b>			<b>SECONDARY INSURANCE TYPE:</b>	
SUBSCRIBER:	DATE OF BIRTH	SUBSCRIBER:	DATE OF BIRTH:	
SUBSCRIBER EMPLOYER:		SUBSCRIBER EMPLOYER:		
EMPLOYERS ADDRESS:		EMPLOYERS ADDRESS:		
_____		_____		
EMPLOYERS PHONE # _____		EMPLOYERS PHONE # _____		
GROUP #	POLICY/CLAIM #	GROUP #	POLICY/CLAIM #	
_____		_____		
MAIL CLAIM TO:		MAIL CLAIM TO:		
_____		_____		
<b>PHONE #</b>		<b>PHONE #</b>		
_____		_____		
AUTHORIZATION/REFERRAL #		AUTHORIZATION/REFERRAL #		
_____		_____		