EAST BAY UPRIGHT MRI
Multipositional Technology

25001 Industrial Blvd. | Suite A | Hayward | California 94545
Phone: (510) 259-1555 | Fax: (510) 259-0155 | Toll Free: (877) 701-7226

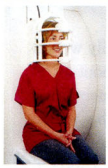
Patient Name:_____ Date of Birth:_____ Male_____ Female_____ Weight_____

Social Security#_____ Telephone W:_____ H:_____ C:_____

Address:_____ City_____ State_____ Zip_____

Chief Complaint(s) and Brief History_____

UPRIGHT/WEIGHT-BEARING

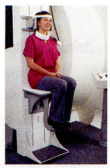


Brain

- ☐ Routine
- ☐ TMJ
- ☐ Posteria Fossa
- ☐ Sinuses
- ☐ IAC's
- ☐ Pituitary
- ☐ Orbits

MRA

- ☐ Circle of Willis
- ☐ Carotid Arteries

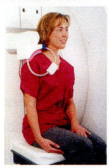


Spine

- ☐ Cervical - specify below
- ☐ Thoracic
- ☐ Lumbosacral - specify below

Lower Joints

- ☐ Hip ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Ankle ☐ L ☐ R



Misc.

- ☐ Shoulder ☐ L ☐ R
- ☐ Elbow ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Prostate

Other: _____

Perform Recumbent Scan for Comparison? ☐ Yes ☐ No

RECUMBENT ONLY

- ☐ Abdomen
- ☐ Pelvis
- ☐ Prostate

- ☐ Brain Specify _____
- ☐ Spine Specify _____
- ☐ Joints Specify _____
- ☐ Other Specify _____

CERVICAL

Recumbent Scan for Comparison? ☐ Yes ☐ No

☐ Neutral

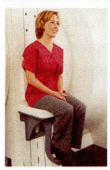
☐ Flexion

☐ Extension

☐ Lateral Bending ☐ L ☐ R

LUMBOSACRAL

Recumbent Scan for Comparison? ☐ Yes ☐ No



☐ Neutral

☐ Flexion

☐ Extension

☐ Lateral Bending ☐ L ☐ R

INSURANCE INFORMATION (We do insurance verification):

_____ Work Comp _____ Auto _____ Personal Injury _____ Lien Date of Incident _____

Claim Number _____ Adjuster Name _____

Name of Carrier _____ Phone Number _____

Attorney Name _____ Phone Number _____

Primary Insurance _____ Group # _____

Policy Number _____ Insurance Phone _____ Secondary Insurance ☐ Yes ☐ No

URGENT CARE ☐ Yes ☐ No **WITH CONTRAST?** ☐ Yes ☐ No

Special Instructions or Comments: _____

Physician's Name:_____ Phone:_____ Physician's Signature: *x* _____