

EAST BAY
UPRIGHT
MRI

25001 Industrial Blvd., Suite #A

Hayward, CA 94545

877-701-7226 / 510-259-1555 / Fax 510-259-0155

PATIENT HISTORY / DATA SHEET

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ City: _____ State: _____ Zip: _____

SOCIAL SECURITY NO. _____ DATE OF ACCIDENT _____

TYPE OF SCAN _____ SCAN DATE _____

CONTRAST: YES NO

REFERRING DR. _____

DR. PHONE _____ DR. FAX _____

I, the undersigned, verify that all the answers I have provided to be true, to the best of my knowledge. I give **VISION MRI CENTER** permission to perform the examination(s) requested by my physician. I authorize the release of any medical information necessary to process this claim. I understand that I am responsible for all copayments, coinsurance and services deemed "not covered" by my insurance company (if applicable). I also authorize payment of medical benefits to **VISION MRI CENTER** for services rendered

I, the undersigned, will re-direct payment to Vision Upright MRI, in the case where my insurance company sends payment to me.

I have read the above and fully understand its content, and all my questions have been answered.

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE IF MINOR _____