EAST BAY UPRIGHT MRI
Multipositional Technology

PATIENT INFORMATION:

**Indicates this is a required field.*

*Name:		*Date of Birth:		SSN: (optional)	
Weight:		Gender:	○ Male ○ Female		
Phone Work:		*Home:		Cell:	
*Address:		*City:		State	CA
*Zip:					

Complaint:

UPRIGHT/WEIGHT BEARING

Brain
- ☐ Routine
- ☐ TMJ
- ☐ Posteria Fossa
- ☐ Sinuses
- ☐ IACs
- ☐ Pituitary
- ☐ Orbits

MRA
- ☐ Circle of Willis
- ☐ Carotid Arteries

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

Misc.
- ☐ Shoulder ☐ L ☐ R
- ☐ Elbow ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Prostrate

Lower Joints
- ☐ Hip ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Ankle ☐ L ☐ R

WITH CONTRAST? ☐ Yes ☐ No ☐ Both Perform Recumbent Scan for Comparison? ○ Yes ○ No

CERVICAL CONTRAST? ☐ Yes ☐ No ☐ Both
☐ Neutral ☐ Flexion ☐ Extension

LUMBOSACRAL CONTRAST? ☐ Yes ☐ No ☐ Both
☐ Neutral ☐ Flexion ☐ Extension

RECUMBENT ONLY

- ☐ Abdomen
- ☐ Pelvis
- ☐ Prostrate
- ☐ Brain Specify
- ☐ Spine Specify
- ☐ Joints Specify
- ☐ Other Specify

PLEASE COMPLETE ALL THE INFORMATION SO THAT WE MAY EXPEDITE THE SCHEDULING OF YOUR PATIENT.

INSURANCE INFORMATION (we do insurance verification):

What type of coverage? *At least one Coverage Type must be checked.*
☐ Insurance ☐ Work Comp ☐ Auto ☐ Personal Injury ☐ Lien ☐ Third Party ☐ Cash

Incident Date:

Claim Number:		Adjuster Name:	
*Carrier Name:		*Phone Number:	
Attorney Name:		Phone Number:	
*Primary Insurance:		Group Number:	
*Policy Number:		*Insurance Phone:	

Please indicate your images delivery preference.
- ☐ Hand Deliver Films
- ☐ Film to Patient
- ☐ CD to Patient
- ☐ View Images Online

Secondary Insurance ○ Yes ○ No

PHYSICIAN INFORMATION

Special Instructions or Comments:

Office Contact Name:		*Office Contact Email:		QME on Case?	○ Yes ○ No
*Physician's Name:		*Physician's Phone:		Fax:	
Physician's Address:		*Specialty:		*Diagnostic Code:	