PARAMUS MRI
ACR ACCREDITED

30 West Century Road • Suite 100 Paramus, NJ 07652
tel: 201.483.6955 • *fax:* 201.483.6956
info@paramusmri.com • www.paramusmri.com

NJ MVA/PIP

PERSONAL INFORMATION

Last Name_____First Name_____M.I_____

Address_____City_____State_____Zip Code_____

Home #_____ Cell#_____Work_____

SS#_____ D.O.B_____ Sex_____Wt_____Ht_____

EMERGENCY CONTACT

Relation to Patient _____

Last Name_____ First Name_____ M.I._____

Address_____City_____State_____Zip Code_____

Home#_____Cell#_____Work_____

ACCIDENT INFORMATION (if applicable)

Name of Policy Holder_____ Policy #_____

Name of Insurance Company _____Claim#_____

Date of Accident _____State of Occurence _____

Adjuster's Name _____ Phone # _____ Ext. _____

PRIMARY HEALTH INSURANCE

Name of Insurance company _____Member ID#_____

Insured Name_____Relationship to Patient_____

SECONDARY HEALTH INSURANCE (if applicable)

Name of Insurance company _____Member ID#_____

Insured Name_____Relationship to Patient_____

ATTORNEY INFORMATION (if applicable)

Attorneys Name _____

Address _____

Phone #_____ Fax_____

EMPLOYER INFORMATION (if applicable)

Employer Name _____

Phone #_____

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New Jersey Application for Benefits Personal Injury Protection

Date:	Type of Claim:	Date of Accident:	Claim Number:
Your Name:	Gender:	Phone Nos.: Home: Mobile:	
Your Address:	Date of Birth:	Social Security No.:	
Your Previous Address:			
Date of Accident:	Time of Accident:	Place of Accident:	
Brief Description of Accident:			

Do you or any member of your household own a vehicle? Yes ☐ No☐ Name of Insurance Company: Do you have health insurance? Yes ☐ No☐ Name of Insurance Company:	Were you the driver of the vehicle? Yes ☐ No ☐ Were you a passenger in the vehicle? Yes ☐ No ☐ Were you a pedestrian? Yes ☐ No ☐ Are you a member of vehicle's owners household? Yes ☐ No ☐

As a result of this accident, were you injured? Yes ☐ No☐ If your answer is "Yes," complete the remainder of this form. If "No," sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury:

Were you treated by a doctor? Yes ☒ No☐	Doctor's Name and Address:
If you were treated in a hospital, were you Inpatient? ☐ Outpatient? ☐	Hospital's Name and Address:

Amount of Medical Bills to Date: $	Will you have more medical expenses? Yes ☒ No☐	At the time of your accident, were you in the course of your employment? Yes ☐ No■	Did you lose wages or salary as a result of your injury? Yes ☐ No☐ If yes, Amount loss to date:	What is your average weekly wage or salary?

Date Disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:

	Yes	No
(1) Any Worker's Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number: (HICN)

List names and Address of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No☐ If your answer is "Yes," please explain:

Signature: ▶ _____ Date: _____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or Treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Personal Injury Protection Benefit Law.

Signature: ▶ _____ Date: _____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to prove this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____
Social Security Number: **«F13»**

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

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TO OUR VALUED PATIENTS
PLEASE CIRCLE **YES** OR **NO**

HAVE YOU EVER BEEN AT THIS FACILITY BEFORE

YES OR NO

☐ ☐

HAVE YOU EVER HAD AN MRI OF THE SAME BODY PART THAT YOU ARE SCHEDULED FOR TODAY?

YES OR NO

☐ ☐

IF YES,

DATE OF EXAM: _____

PLEASE LIST FACILITY: _____

(PLEASE SIGN): _____

FOR INTERNAL USE:

Contacted: _____

Results: _____

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MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ☐ Female ☐ Body Part to be Examined _____
month day year

Address _____ Telephone (home) (_____) _____-_____

City _____ Telephone (work) (_____) _____-_____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (_____) _____-_____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☐ Yes
   If yes, please list:

	Body part	Date	Facility
MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other_____	_____	_____/_____/_____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list: _____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ☐ No ☐ Yes
   If yes, please describe: _____

For female patients:

10. Date of last menstrual period:_____/_____/_____ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? ☐ No ☐ Yes

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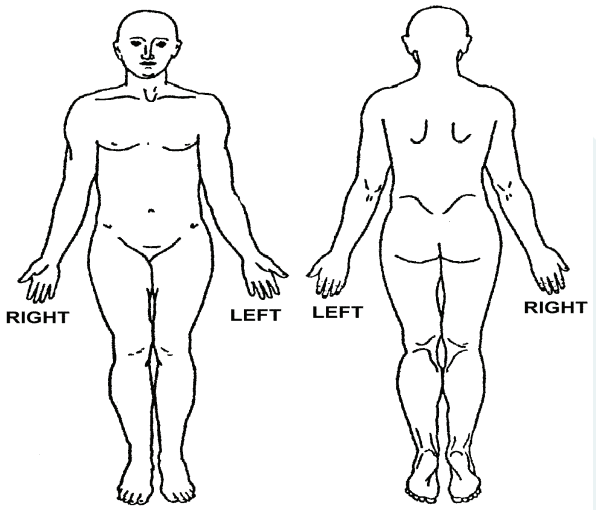
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Metallic stent, filter, or coil
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid
  (Remove before entering MR system room)
- ☐ Yes ☐ No Other implant _____
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

❒ MRI Technologist ❒ Nurse ❒ Radiologist ❒ Other_____