



PARAMUS MRI  
ACR ACCREDITED

30 West Century Road • Suite 100 Paramus, NJ 07652  
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**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 Occurrence \_\_\_\_\_  
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 # \_\_\_\_\_

## New Jersey Application for Benefits Personal Injury Protection

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| Date:  |  | Type of Claim:  |  | Date of Accident:                               |  | Claim Number:  |   |  |
| Your Name:   |  |   | Gender:  |   | Phone Nos.: Home:<br>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 <input type="checkbox"/> No <input type="checkbox"/>   |  |   |  | Were you the driver of the vehicle?             |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| Name of Insurance Company:   |  |   |  | Were you a passenger in the vehicle?            |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| Do you have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |   |  | Were you a pedestrian?                          |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| Name of Insurance Company:   |  |   |  | Are you a member of vehicle's owners household? |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| As a result of this accident, were you injured? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |   | Doctor's Name and Address:   |   |  |  |   |  |
| If you were treated in a hospital, were you Inpatient? <input type="checkbox"/><br>Outpatient? <input type="checkbox"/>  |  |   | Hospital's Name and Address:   |   |  |  |   |  |
| Amount of Medical Bills to Date:<br>\$   |  | Will you have more medical expenses?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | At the time of your accident, were you in the course of your employment?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | Did you lose wages or salary as a result of your injury?<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>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 <input type="checkbox"/> No <input type="checkbox"/>   |   | If yes, amount: \$   |  |   | Per week <input type="checkbox"/> Per month <input type="checkbox"/> |
| (1) Any Worker's Compensation Law?   |  |   | <input type="checkbox"/> <input type="checkbox"/>  |   |  |  |   |  |
| (2) Employees' Temporary Disability Benefit Statute?   |  |   | <input type="checkbox"/> <input type="checkbox"/>  |   |  |  |   |  |
| (3) Medicare?  |  |   | <input type="checkbox"/> <input type="checkbox"/>  |   | If you are a Medicare beneficiary, enter your Health Insurance Claim Number:<br>(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 <input type="checkbox"/> No <input type="checkbox"/> If your answer is "Yes," please explain:   |  |   |  |   |  |  |   |  |
| <p>Signature:  _____ Date: _____</p> <p style="text-align: center;">Authorization for Medical Information</p> <p>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.</p> <p>Signature:  _____ Date: _____</p> <p style="text-align: center;">Authorization for Medical Information</p> <p>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.</p> <p>Signature: _____ Date: _____</p> <p>Social Security Number: _____</p> <p>"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."</p> |  |   |  |   |  |  |   |  |



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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: \_\_\_\_\_



**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: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

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

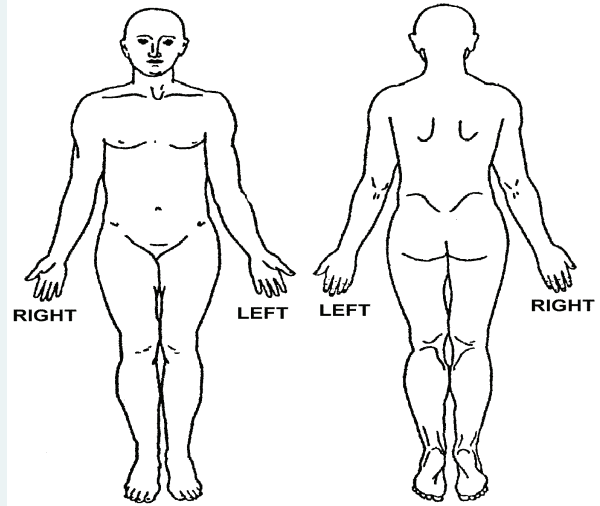


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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 \_\_\_\_\_