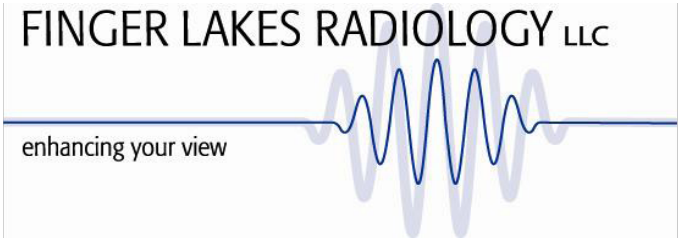

FOR YOUR PRIVACY, PLEASE COMPLETE THIS INFORMATION SHEET SO WE DON'T HAVE TO ASK YOU THIS INFORMATION IN FRONT OF OTHER PATIENTS, THANK YOU.

Name _____

Date of Birth_____**Gender**_____

Address _____

ZipCode _____

Phone Number _____ _____

Employer _____

Employer's address _____

1. Race (Please Circle): White Black/African American Asian
American Indian/Alaskan Native Hawaiian/Pacific Islander Other

2. Ethnicity(Please Circle): Spanish/Hispanic Origin Non Spanish/Hispanic Origin

3. Primary Language:_____

4. Primary Care Physician: _____

WHAT INSURANCE COMPANY WILL BE COVERING THIS EXAM ?

Can we contact you in regards to the service and patient care that you received today?
_____YES _____NO

PLEASE BE ADVISED: YOU WILL BE GIVEN A CD CONTAINING YOUR MRI EXAM AFTER YOUR APPOINTMENT TODAY. THIS IS PROVIDED TO YOU AT NO ADDITIONAL COST. IF IN THE FUTURE YOU SHOULD NEED ANOTHER COPY OF YOUR EXAM, THERE WILL BE A CHARGE OF $5.00 PER CD PAYABLE AT THE TIME OF PICK UP.

Co-payments are due at the time of service.

I ACKNOWLEDGE THE ABOVE STATEMENT.

_____ _____
PATIENT SIGNATURE **Date**

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