



3101 Lake Street, Suite 102
Lake Charles, LA 70601
Ph: (337) 562-0646

MEDICAL RECORDS

Name: _____

Chart #: _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____ **Alternate #:** _____

Date of Birth: _____ F M **Marital Status:** Single Married Divorced

Employer: _____

Employment Status: Full-time Part-time

Exams: _____

Insurance: _____

Referral Doctor: _____

High Field

Low Field

I hereby authorize Open Air MRI of Lake Charles to release and/or receive any and all information: (1) information requested by my insurance company or workman's compensation carrier (2) information to any hospital or physician I may be referred to and/or (3) information from hospital or physician who has previously rendered me treatment. I understand that I am ultimately responsible for payment of any and all charges and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full. I hereby authorize payment of medical benefits to Open Air MRI of Lake Charles.

Patients Name (Print): _____

Signature of Patient or Guardian: _____

Please describe your pain, injury, or discomfort in detail: _____

How long have you been experiencing these symptoms? _____

Any previous exams (example: MRI/CAT Scan) relating to this problem? _____

Do you have decreased renal function or undergoing renal dialysis? Yes No

If on dialysis, when is your next dialysis appointment? _____

Pacemaker	Yes	No	Prosthesis	Yes	No
Sickle Cell Anemia	Yes	No	Ear Implants	Yes	No
Aneurysm Clips	Yes	No	Hearing Aids	Yes	No
Pregnant	Yes	No	Heart Valves	Yes	No
Breastfeeding	Yes	No	Liver Disease	Yes	No
Iud/diaphragm	Yes	No	Metal In Eyes	Yes	No
Surgical Metal	Yes	No	Stents/pumps	Yes	No
Blood Disorder	Yes	No	Previous Surgeries Related		
Gunshot Wound Or Shrapnel	Yes	No	to this exam	Yes	No
Do You Have A History Of Cancer	Yes	No	Other implants	Yes	No
Bone/neuro Stimulator	Yes	No	Specify _____		