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: ______________________________

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How long have you been experiencing these symptoms? ______________________________

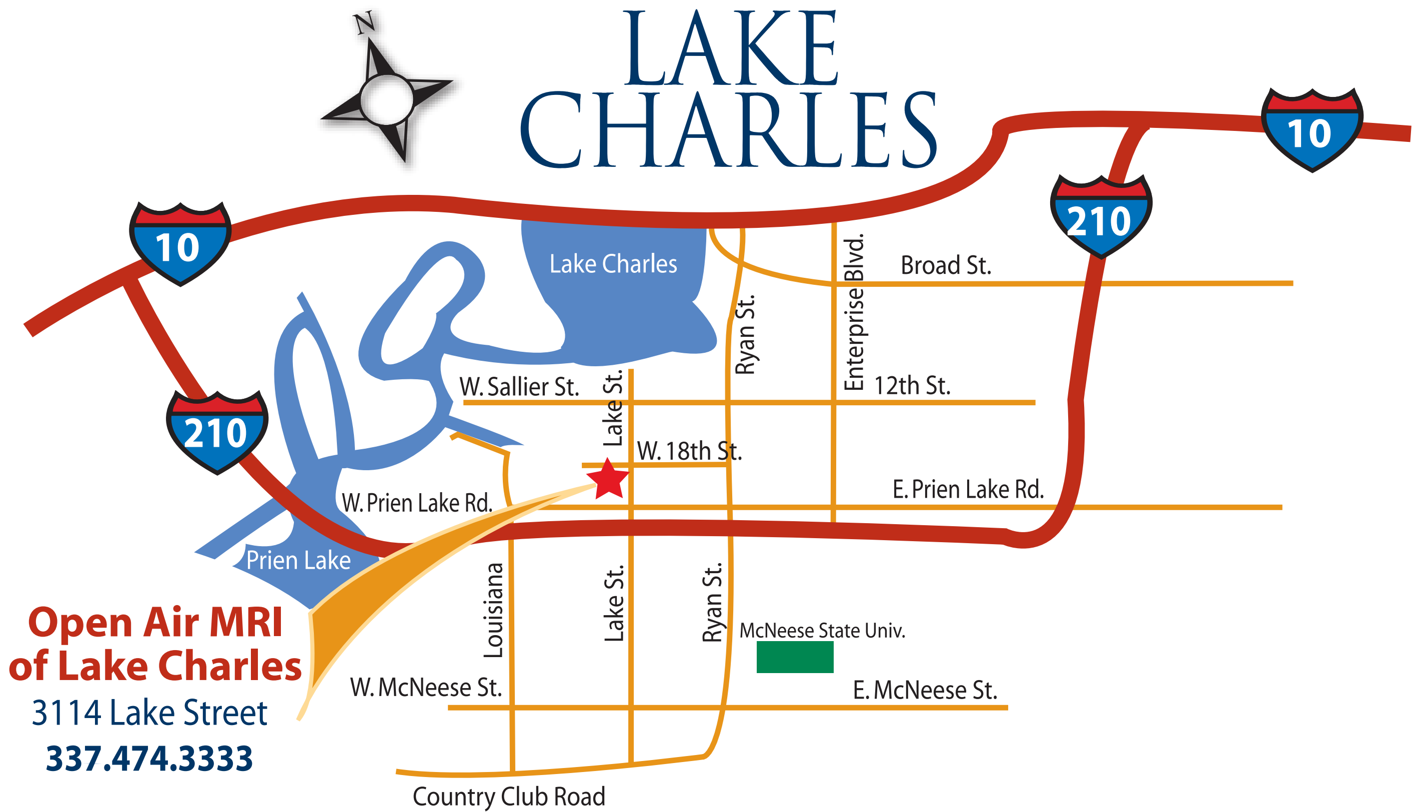
Any previous exams (example: MRI/CAT Scan) relating to this problem? ______________________________

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

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

Pacemaker	Yes	No
Sickle Cell Anemia	Yes	No
Aneurysm Clips	Yes	No
Pregnant	Yes	No
Breastfeeding	Yes	No
Iud/diaphragm	Yes	No
Surgical Metal	Yes	No
Blood Disorder	Yes	No
Gunshot Wound Or Shrapnel	Yes	No
Do You Have A History Of Cancer	Yes	No
Bone/neuro Stimulator	Yes	No

Prosthesis	Yes	No
Ear Implants	Yes	No
Hearing Aids	Yes	No
Heart Valves	Yes	No
Liver Disease	Yes	No
Metal In Eyes	Yes	No
Stents/pumps	Yes	No
Previous Surgeries Related to this exam	Yes	No
Other implants	Yes	No
Specify ______________________		



PATIENT NOTES

You may be asked to remove your eye make-up, hearing aids, eye glasses, dentures, and jewelry. You will be provided with a locker to hold your personal items at the time of this exam.

Please notify our staff if any of the following pertain to you:

- Aneursym Clip
- Brain Surgery
- Vascular Surgery
- Metal Rods
- Inner Ear Prosthesis
- Prosthetic Heart Valve
- Pregnant