3909 Waring Road, Suite C
Oceanside, CA 92056
Phone (760) 630-0014
Fax (760) 630-0015

REGENTS IMAGING

Last Name___________________________ First__________________ MI_____SEX___AGE______

Address___________________________________ City_________________State_______ZIP___________

Home Phone(   )___________________________Work Phone (   )__________________________

Date Of Birth______/______/______   Height_______________   Weight______________

Employer ____

Date Of Accident __________________________ Work Related?__________Auto?___________

Referring Physician_________________________________ Primary Physician___________________________

Screening Contraindication

(PLEASE EXPLAIN ANY "YES" ANSWERS)

Pacemaker, pacer wires, implanted cardiac defibrillator? If YES, please notify us IMMEDIATELY!   YES / NO
Brain aneurysm clip? If YES, please notify us IMMEDIATELY!________________________________YES / NO
Have you ever had an MRI scan before?____YES / NO
If yes, list date of last MRI. _______/_______/________ What area of the body was scanned?____________
Have you *EVER* had a metal injury to your eyes? If YES, please notify us IMMEDIATELY!_______ YES / NO
Have you had an MRI since the incident of metal to your eyes?__________________________________YES/ NO
Are you claustrophobic?____YES / NO
Do you have any allergies to medications or latex products?____________________________________YES / NO
Could you be pregnant?_If YES, please notify us IMMEDIATELY!_____________________________YES / NO
Are you breast feeding?____ YES / NO

PLEASE CIRCLE THE APPROPRIATE RESPONSE

Neuro-stimulator ?	Y / N	Eye prosthesis?	Y / N	Insulin pump?	Y / N
Bone growth stimulator?	Y / N	Inner ear implants?	Y / N	Infusion pump?	Y / N
Joint replacements?	Y / N	(cochlear, stapes)?	Y / N	Morphine pump?	Y / N
Other metal(rods,shrapnel		Tattoos?	Y / N	Magnetic dental implant?	Y / N
Screws,bullets)?	Y / N	Tatooed eyeliner?	Y / N	Removable denture work?	Y / N
Wire/sutures/clips ?	Y / N	Hearing Aids ?	Y / N	Penile implants?	Y / N
Harrington rods?	Y / N				

____   _______________________   ___________

PATIENT SIGNATURE OR REPRESENTATIVE   MRI TECHNOLOGIST   DATE

REVIEWED_____________