MRI RESEARCH INSTITUTE

Patient ID # _____

1321 Cumberland Falls HWY. – Corbin, KY 40701

PATIENT INFORMATION SHEET

DATE:_____SOCIAL SECURITY#:_____MARITAL STATUS: S M D W

NAME:_____ DATE OF BIRTH:_____ AGE:_____SEX: M F

ADDRESS:_____CITY_____STATE_____ZIP_____

HOME PHONE:_____CELL PHONE:_____WORK # :_____

IF PATIENT IS A MINOR(Under 18), PLEASE LIST PARENT OR GUARDIAN

FATHER/MOTHER_____SS#_____DOB_____

NAME OF REFERRING PHYSICIAN:_____ PHARMACY:_____

REASON FOR VISIT:_____ALLERGIES:_____

CURRENT MEDICATIONS: _____

☐ Headaches	784.0	☐ Shooting Pain Legs	724.4	☐ Muscle Spasms	728.85	☐ Lung Disease	
☐ Dizziness	780.4	☐ Leg Pain	729.5	☐ Muscle Weakness	728.87	☐ Heart Disease	
☐ Neck Pain/Stiffness	723.1	☐ Memory Loss	780.93	☐ Muscle Cramps	729.82	☐ Kidney Disease	
☐ Arm/Shoulder Pain	719.41	☐ Ears Ringing	388.30	☐ Hypertension		☐ Thyroid Disease	
☐ Pins/ Needles Arm	782.0	☐ Blurred Vision	368.8	☐ Angina		☐ Other	
☐ Fainting	780.2	☐ Upper Back Pain	724.1	☐ Diabetes			
☐ Numbness/ Tingling	782.0	☐ Mid Back Pain	724.1	☐ Cancer			
☐ Shooting Pain Arms	723.4	☐ Lower Back Pain	724.2	☐ Tuberculosis			

INSURANCE INFORMATION

NAME OF INSURANCECOMPANY:_____ AUTO: Y / N WORK COMP Y / N

POLICY HOLDER:_____RELATIONSHIP:_____

DOB for POLICY HOLDER: _____SSN # for POLICYHOLDER:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY THE FOLLOWING INDIVIDUAL(S)

NAME:_____

RELATIONSHIP TO PATIENT:_____PHONE #_____

NEAREST RELATIVE NOT LIVING WITH YOU:_____

RELATIONSHIP TO PATIENT:_____PHONE #_____

PLEASE SIGN BELOW

I hereby authorize payment of medical benefits to Dubin Orthopaedic Centre, P.S.C. for professional services rendered as well as authorizing the release of any information necessary to process this claim. I also grant Dubin Orthopaedic Centre, P.S.C. permission to release copies of my records to my family and/or referring physicians. I understand that for some reason if my insurance company refuses payment for services rendered by Dubin Orthopaedic Centre, P.S.C. , that these will become my responsibility.

_____

Signature of *Patient* or if under 18, Parent or Legal Guardian **Date**

Acknowledgment Of Receipt of Notice of Privacy Practices

By signing this form I acknowledge that I have been provided with Dubin Orthopaedic Centre, P.S.C. Notice of Privacy Practices to review and informed that I may keep a copy of reference or obtain a copy upon request.

_____

Date