

**Gainesville Open MRI**  
PATIENT INFORMATION/VERIFICATION

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOW(ER) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN #: \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATIONSHIP TO INSURED \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP PLAN #: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP PLAN #: \_\_\_\_\_

ATTORNEY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

DO YOU HAVE A FOLLOW UP APPOINTMENT? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, WHEN? \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

WOULD YOU LIKE US TO SEND THIS MRI REPORT TO ANY DOCTOR NOT LISTED? \_\_\_\_\_

IS YOUR CONDITION RELATED TO:

EMPLOYMENT? YES \_\_\_\_\_ NO \_\_\_\_\_ INJURY DATE: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

ACCIDENT? YES \_\_\_\_\_ NO \_\_\_\_\_ INJURY DATE: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ALL THAT APPLY)

\_\_\_\_\_ TELEVISION \_\_\_\_\_ RADIO \_\_\_\_\_ FRIEND \_\_\_\_\_ BEEN HERE BEFORE \_\_\_\_\_ OTHER