



Patient Name: _____ Date of Birth: _____ Male _____ Female _____ Weight _____

Social Security# _____ Telephone W: _____ H: _____ C: _____

Address: _____ City _____ State _____ Zip _____

Chief Complaint(s) and Brief History _____

UPRIGHT/WEIGHT-BEARING



Brain

- Routine
- TMJ
- Posteria Fossa
- Sinuses
- IAC's
- Pituitary
- Orbits

MRA

- Circle of Willis
- Carotid Arteries



Spine

- Cervical - specify below
- Thoracic
- Lumbosacral - specify below



Lower Joints

- Hip L R
- Knee L R
- Ankle L R



Misc.

- Shoulder L R
- Elbow L R
- Wrist L R
- Prostate
- Other: _____

Perform Recumbent Scan for Comparison? Yes No

RECUMBENT ONLY



- Abdomen
- Pelvis
- Prostate

Brain Specify _____

Spine Specify _____

Joints Specify _____

Other Specify _____

CERVICAL Recumbent Scan for Comparison? Yes No



Neutral Flexion Extension Lateral Bending L R

LUMBOSACRAL Recumbent Scan for Comparison? Yes No



Neutral Flexion Extension Lateral Bending L R

INSURANCE INFORMATION (We do insurance verification):

Work Comp _____ Auto _____ Personal Injury _____ Lien _____ Date of Incident _____

Claim Number _____ Adjuster Name _____

Name of Carrier _____ Phone Number _____

Attorney Name _____ Phone Number _____

Primary Insurance _____ Group # _____

Policy Number _____ Insurance Phone _____ Secondary Insurance Yes No

URGENT CARE Yes No

WITH CONTRAST? Yes No

Special Instructions or Comments: _____

Physician's Name: _____ Phone: _____ Physician's Signature: x _____