Lakes Imaging Center
2019 South 6th Street
Brainerd, MN 56401
218-822-6736 / 877-522-7222
Fax: 218-822-3758

MR#______________________
{for office use only}

Patient Information

Date of test:____________________

Last Name: ________________________ First Name:________________________ Middle Initial: _______

Mailing Address:____

City:_________________________________ State:_____________ Zip Code: ________________________

Home #:_________________________ Work#: _____________________Cell#:_______________________

____M ____F DOB: _____/_____/_______ Age: _______ Social Security#:_______-______-_______

Parent or Guardian:____

Referring Physician

Name:_____________________________________Clinic: ____

Primary Care Physician

Name:_____________________________________Clinic: ____

Emergency Contact

Name:_____________________________________Relationship to Patient:_________________________

Home #:_________________________ Work#: _____________________Cell#:_______________________

PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT

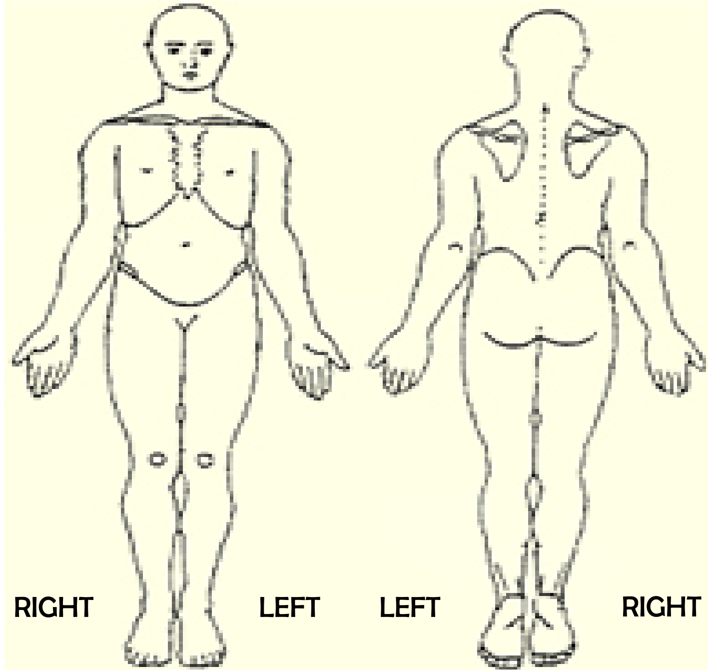
The physicians of Northern Orthopedics, Ltd. and Diagnostic Imaging Specialists, P.A. maintain ownership in Lakes Imaging Center.

Lakes Imaging, L.L.C.

Date: ____________________

Patient Name: ____________________

Please shade in the painful area.



Describe your pain: ____________________

____

____

____

____

Injury Date: ____________________

Allergies: ____________________

Current Medications: ____________________

____

____

Have you had surgery in the area to be scanned? ____

If yes, when? ____________________

Type of surgery: ____________________

Facility where surgery was done: ____________________

I understand the procedure. The information above is correct and I wish to have the MRI test done.

Patient/Guardian Signature Date

Prior to having your MRI it is important to know if you have any of the following:

	Yes	No
1. Implanted defibrillator	____	____
2. Pacemaker	____	____
3. Electrical devices	____	____
4. Brain surgery	____	____
5. Blood vessel surgery	____	____
6. Middle ear implant	____	____
7. Heart valve	____	____
8. Permanent eyeliner	____	____
9. War injury/gunshot wound	____	____
10. Any other type of metal in your body	____	____
11. Have you ever welded, worked with sheet metal, grinding metal or been a machinist?	____	____
12. Are you pregnant? . . . . Date of LMP? ____________	____	____
13. Do you wear hearing aids?	____	____
14. Do you wear dentures?	____	____
15. Do you have seizures?	____	____
16. Do you have diabetes?	____	____
17. Do you have a heart condition?	____	____
18. Do you have any respiratory problems?		
19. Are you claustrophobic?	____	____
20. Do you have any physical handicaps?	____	____
21. Have you ever been diagnosed with cancer?	____	____

If yes, type: ____________________

Date of Diagnosis: ____________________

Please list and date any x-rays, Ct scans or diagnostic exams of the area to be scanned:

____

____

____

____

Orbits Cleared by: ____________ Date: ____________

Technologist's Signature Date