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**MRI PATIENT DATA SHEET**

Study Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Study Ordered: \_\_\_\_\_

**Patient History**

- Metal In Eyes  Y  N
- Pacemaker  Y  N
- Metallic Implants  Y  N
- Pregnant  Y  N
- Previous Surgery  Y  N

**Tech Initials**

- Hair Implants  Y  N
- Head & Neck Surgery  Y  N
- Intracranial Clips  Y  N

Type: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Previous MRI:  Y  N

Additional History: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Patient Signature: \_\_\_\_\_