EAST RIVER
MEDICAL IMAGING, PC

PATIENT INFORMATION RECORD

Date: 06/05/2018 Medical Record Number #: 0315192

Patient Name: EPSTEIN, JEFFREY Social Security #: [redacted]

Address: 6100 RED HOOK QUARTERS Apt/Unit/Suite: APT B3

City: SAINT THOMAS State: VI Zip: 00802 E-Mail:

Date of Birth: 01/20/1953 Primary Phone #: [redacted]

Please validate your referring physician and contact information by marking the check boxes below.

- ☐ Referring Physician: MOSKOWITZ, BRUCE W, M.D, M.D.
- ☐ Referring Physician's Address: 1411 NORTH FLAGLER DRIVE SUITE 7100 WEST PALM BEACH, FL 33401
- ☐ Referring Physician's Phone: [redacted]

Your referring Physician that has ordered this procedure will receive reports, films and/or CD (their preference). Please indicate by marking in the check box if you would like any additional processing to yourself or other physicians

Additional Physicians Name: _____ Address: _____

Additional Reports To: _____ Address: _____

☐ Report Only **(No Charge)** ☐ Report & CD **($25.00)** ☐ Report & Films **($200.00)**

Insurance Information

Insurance Company: Group #:

Insured's Name: Insured's DOB:

Insured's ID#: Relation to patient:

Do you have supplemental/secondary insurance? ☐ Yes ☐ No

If yes, Insurance Company: Insured's ID #:

Has your insurance changed since your last visit? ☐ Yes ☐ No

(**if yes**, please fill out insurance information above and supply your new insurance card(s) to the front desk receptionist.)

EXAMS TODAY

Date / Time	Exam Code	Referring Name	Accession
06/05/2018 8:30 AM EDT	MRCLAVL	MOSKOWITZ, BRUCE W, M.D	7156124

PAYMENT IS DUE AT THE TIME OF SERVICE

☐ Cash ☐ Check ☐ Mastercard ☐ Visa ☐ Amex ☐ Discover

I HEREBY ACKNOWLEDGE THAT I AM FULLY RESPONSIBLE FOR ANY UNPAID BALANCES.

Signature of Patient or Guardian: _____

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OUTSIDE FILMS/CD FORM

Date: 5/30/18

Patient Name: EPSTEIN, JEFFREY

Medical Record Number #: 0315192

Do you have any relevant outside studies (films/CD) with you?

☐ Yes ☐ No

If Yes, please check the box as to how you would like your outside images returned

☐ Upload CD to our system and take back with you

☐ Return CD/Film to my home address on file

☐ Return CD/Film to my referring physician

Patient Signature _____

Front Desk Receptionist Name _____

Front Desk Receptionist Signature _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, EPSTEIN, JEFFREY , have received the Notice of Privacy Practices from East River Medical Imaging, PC.

PATIENT SIGNATURE: _____ 5/30/18

In lieu of patient signature, I, _____, a staff member of East River Medical Imaging, PC state that the patient named above has been given our current Notice of Privacy Practices.

STAFF SIGNATURE: _____ DATE: _____

PATIENT NAME: EPSTEIN, JEFFREY
0315192

EAST RIVER MEDICAL IMAGING, PC

MAGNETIC RESONANCE IMAGING (MRI)

Patient Name: EPSTEIN, JEFFREY MRN #: 0315192 Exam Code: MRCLAVL

Age: 65 Years Sex: M Height: Feet Inches Weight: lbs Exam Date: 06/05/2018

Referring Physician: MOSKOWITZ, BRUCE W. M.D. M.D. Acc# 7156124

IMPORTANT: Please notify the receptionist if you answer **"YES"** to any of the questions below. The receptionist will inform the technologist/radiologist of your response.

YES	NO	PLEASE CHECK:
☐	☐	Have you had metal removed from your eyes?
☐	☐	Have you been shot with bullets, BB's or shrapnel?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?
☐	☐	Are you on hemodialysis or peritoneal dialysis?
☐	☐	Do you require oxygen or an inhaler?
☐	☐	Do you have renal disease? If yes please describe _____
☐	☐	Are you wearing any metallic items?
☐	☐	Any surgery on the area to be imaged? If yes, when? _____
☐	☐	Any surgery on your eyes, ears brain or heart?
☐	☐	Have you had a Colonoscopy and/or Endoscopy within the last 6 weeks? If yes, date of exam _____

YES	NO	DO YOU HAVE ANY OF THE FOLLOWING IN YOUR BODY?
☐	☐	Brain/Aneurysm Clips
☐	☐	**Pacemaker, Pacer Wires or Defibrillator** if yes, make\ year _____
☐	☐	Any Metallic fragment or foreign body
☐	☐	Ear Implants or Hearing Aids
☐	☐	Electrical Stimulators
☐	☐	Implant/Prosthesis
☐	☐	Infusion Pumps
☐	☐	Coils, Catheters, Filters or Wires in blood
☐	☐	Artifical Limbs or Joint Replacement
☐	☐	Tattooed Eyeliner
☐	☐	Artificial Heart Valves
☐	☐	Stents If yes, please provide date of implant: _____
☐	☐	Magnetic Dental Implants
☐	☐	Transdermal Patches
☐	☐	IUD
☐	☐	Tissue expander for future implants
☐	☐	Bone Stimulators, Insulin Pumps, or Mechanical Valves
☐	☐	Programmable Shunts

WARNING: **Before entering the MR room, you must remove all metallic objects including HEARING AIDS, DENTURES, CREDIT/BANK CARDS, watch, keys, cell phone, beeper, hair pins, barrettes, body piercing jewelry, money clips, magnetic strip cards, pens, pocket knife, and nail clipper. Please consult the technologist if you have any questions or concerns BEFORE you enter the MR room.**

Signature: _____ Print Name: _____ Date: 06/05/2018

Technologist's Use Only

Patient Complaint/Diagnosis: _____

Any previous imaging studies in this area? ☐ YES ☐ NO

If yes, where? _____

Technologist: _____ Wet Reading ☐ YES ☐ NO Dr's Phone Number: _____

EAST RIVER MEDICAL IMAGING, PC

SIGNATURE ON FILE/INSURANCE AUTHORIZATION CARD

* I AUTHORIZE USE OF THIS FORM FOR ALL MY INSURANCE SUBMISSIONS;
* I AUTHORIZE THE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANY(S);
* I UNDERSTAND I AM RESPONSIBLE FOR MY BILL.
* I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY(S);
* I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR; AND
* I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PATIENT NAME: EPSTEIN, JEFFREY
ID NUMBER:

DATE: 06/05/2018

PATIENT SIGNATURE: _____

FOR OFFICE USE ONLY:

MRN#: 0315192

Signature on File Form 02-2007