



1103 Westwood Drive, P.O. Box 1555
Hamilton, MT 59840
PHONE: 406.363-7439 FAX: 406.363-5221

Patient Information (Please Print)

Patient Name _____ Date of Birth _____
(Last) (First) (MI)

Mailing Address _____

(City) (State) (Zip) Home Phone _____

Cell Phone _____ Sex (M/F) _____ Social Security # _____

Occupation _____ Employer _____

Employer's Address _____ Work Phone _____

Spouse's Name _____ D.O.B. _____ S.S.N. _____

Spouse's Employer _____ Work Phone _____

In Case of Emergency Please Contact _____ Phone _____

How did you hear about us? _____

Parent/Guardian Information if Patient is a Minor:

Father/Guardian Name _____ D.O.B. _____ S.S.N. _____

Address (if different from patient's) _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Phone _____

Mother/Guardian Name _____ D.O.B. _____ S.S.N. _____

Address (if different from patient's) _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Phone _____

Health Insurance Information: (Please present your insurance card(s) to receptionist)

Primary Insurance _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insured Name _____ S.S.N. _____ Birthdate _____

Policy ID# _____ Group# _____

Secondary Insurance _____

Address _____ City _____ State _____ Zip _____

Insured Name _____ S.S.N. _____ Birthdate _____

Policy ID# _____ Group# _____

Patient Information (Continued)

Accident Information (If Applicable):

Date of Accident _____ Worker's Compensation or auto accident or other
Part of body injured _____
Insurance carrier _____ Phone _____
Address _____ City _____ State _____ Zip _____
Claim or Policy # _____ Name of adjustor _____
Employer (if different from above) _____ Phone _____

Assignment and Release Information:

Note: It is the patient's responsibility to assure coverage and obtain any necessary pre-authorization from their insurance carrier. I hereby authorize Bitterroot Imaging Open MRI, L.L.C. to release any information acquired during the course of my studies to the insurance company, my physician and his associates. I also authorize payment benefit directly to Bitterroot Imaging. By signing below I recognize and accept responsibility for any balance remaining after payment of benefits.

Important Safety Notice

Important Instructions:

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form before entering the MR environment or MR system room.

Be advised, the MR system magnet is always on.

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beepers, cell phones, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watches, safety pins, paper clips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, steel-toed boots/shoes and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI technologist or radiologist if you have any questions or concerns **before** you enter the MRI system room.

Signature of Responsible Party

Relationship to Patient

Date