Mirage Imaging Center

Medical Director
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Date:_____ Time:_____

Patient Information (Please fill out completely)

Name: _____

DOB: _____ Height: _____

❒ Male ❒ Female Weight: _____

Home Tel: (____) _____

Work Tel: (____) _____

Case Type (Please Check)

❒ Private Insurance ❒ Medicare
❒ Workers' Compensation ❒ Med Pay (Auto Ins)
❒ Cash ❒ Personal injury

Insurance Infomation

Insurance Carrier: _____

ID #: _____ Claim #: _____

History / Additional Information

Referring Doctor

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Tel: (____) _____

Fax: (____)_____ Contact:_____

MRI

❒ With Contrast

❒ Brain
❒ Brain with DWI
❒ Internal Auditory Canal
❒ Cervical Spine
❒ Thoracic Spine
❒ Lumbar Spine
❒ Pelvis
❒ Shoulder R L
❒ Other please specify_____

❒ Elbow R L
❒ Wrist R L
❒ Hand R L
❒ Hip R L
❒ Knee R L
❒ Ankle R L
❒ Foot R L

MR Angiography

❒ Head (C.O.W.)
❒ Neck (CAROTIDS)
❒ Other please specify_____

Ultrasound

❒ Abdomen ❒ Gallbladder ❒ Aorta (AAA)

❒ Pelvis __Endovaginal __Transabdominal

❒ Thyroid ❒ Testicular ❒ Appendix

❒ Kidney/Bladder ❒ Carotid

❒ Venous Extremity __upper __lower __LT __RT

❒ Other _____

Diagnosis

-ICD- 9 Code-

❒ Wet Reading

_____ Date_____

Physician's Signature: