

Patient Information Form

Patient Information: Name _____ Select One: Male Female
Date of Birth _____ Age _____ SS# _____ Phone#: _____ 2nd #: _____
Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Phone _____ Relationship _____
Is this exam Workman Compensation or Auto related? YES NO (Select One)

PLEASE LIST ANYONE BY NAME THAT YOU WOULD LIKE TO RECEIVE YOUR MEDICAL INFORMATION FROM OPEN MRI OF MICHIGAN:

No one other than Myself: _____ Spouse (list name) _____

Other individuals (list names): _____

Fax#: _____

I authorize Open MRI of Michigan or any other associate of Cornerstone Medical Group to discuss my protected health information with the above mentioned persons.

I will provide written notice when I choose to revoke or modify any of the above.

Patient Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____

Dear Patient:

In order to provide better healthcare for you, it is important to know your race, ethnicity and preferred language. Many medical conditions affect certain populations more than others.

We appreciate your cooperation in helping us collect this information.

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Unreported/Refused to report

Race:

- Asian
- Native Hawaiian
- Other Pacific Islander
- Black/African American
- American Indian/Alaska Native
- White
- More than one race
- Unreported/Refused to report

Preferred Language:

- English
- Other
- Indian (including Hindi & Tamil)
- Spanish
- Russian