



*Wasatch Imaging Center, LLC*

**Magnetic Resonance Imaging**

**PATIENT INFORMATION**

Patient's Name (First, Middle, Last)		
Patient's Street Address		
City	State	Zip
Date of Birth	Age	
Sex	Marital Status	
Home Phone #	Cell Phone #	
Employer	Work Phone #	
Occupation		

Account Number \_\_\_\_\_

Scan \_\_\_\_\_

Sx \_\_\_\_\_

Date \_\_\_\_\_

Referring Doctor \_\_\_\_\_

When is your follow up with your Dr.?

\_\_\_\_\_

BROUGHT FILMS

**INSURANCE INFORMATION**

Primary Insurance _____
Name of Insured _____
Relationship _____
Secondary Insurance _____
Name of Insured _____
Relationship _____

**SPOUSE INFORMATION**

Spouse Name (First, Middle, Last)	
Date of Birth	
Employer	Employer Phone

**IF PATIENT IS A MINOR**

Father's Name (First, Middle, Last)	
Date of Birth	
Employer	Employer Phone
Mother's Name (First, Middle, Last)	
Date of Birth	
Employer	Employer Phone

Your information will be given to:

**MOUNTAIN MEDICAL  
PHYSICIAN SPECIALISTS**

**YOU WILL RECEIVE A  
BILL FROM THEM FOR  
THE READING OF YOUR  
MRI**