VALLEY MRI AND RADIOLOGY, INC.

STOCKTON (209)467-1000 LODI (209)366-1000

INTAKE FORM

Patient:	**DOB:**

Reason for today's visit: ______________________________

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REFERRING DOCTOR: ______________________________

ADDITIONAL REPORTS TO: ______________________________

Is your visit due to a job related injury or automobile accident? ☐ **YES** ☐ **NO**
DOI: ____________ ☐ **AUTO** ☐ **WORK** ☐ **OTHER** ____________

Employer:	**Work Phone:**
Employer Address:	**State:**
City:	**Zip:**

WorkComp/Auto Insurance:	
Claim #:	**Phone:**
Adjuster:	
Employer: (At time of injury**):**	

Which insurance are we billing for this exam?
Primary: ______________________________
Secondary: ______________________________
Other: ______________________________

Diabetic ☐ **YES** ☐ **NO** **Heart Disease** ☐ **YES** ☐ **NO**
Type of diabetes: ____________ **HEIGHT:** ____________ **WEIGHT:** ____________

Kidney/liver disease ☐ **YES** ☐ **NO** **High Blood Pressure** ☐ **YES** ☐ **NO**

Any other medical conditions: ______________________________

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Medications: ______________________________

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Signature **Date**