Date: __________

VIP Client Information

First Name: ___________________ Last Name:___________________________________

DOB: _____/_____/_______ Gender: M__ F__

Street Address :____
____
____

City: ___________________ State: ________ Zip Code: ____________________________

Cell Phone: ____________________ Home Phone: ___________________________

Email ____
___

Are you an existing patient of POM MRI & Radiology Centers?

YES________*NO*_________

If YES, prior Date of Service: ____

Are you a returning POMView client? YES______NO____________

Prior Date of Service: ___________________

THANK YOU FOR BEING PROACTIVE WITH YOUR HEALTH. YOUR ARE IMPORTANT!

Date: _________

VIP Client Health & Financial Information

First Name:____________________ Last Name:____

Health:

Are you currently seeing a doctor or specialist, if so who?

____

Clinic name: ____
Phone:____

Tell us why this screening is important to you by listing all medical concerns, past, present, personal or by family history below:
1.____
_______________________2.____
____3.______________________
____
4.____
_______________________5.____
____

Method of payment:

$500 non refundable deposit: Cash __ Credit Card __ CareCredit __

$__________ Balance due: Cash __ Credit Card __ CareCredit __

Care Credit account number and program______________________________________

POM View
Identifying health problems in time

Date: _________

Prescreening and Scheduling

First Name: __________________ Last Name: ______________________

Package interested in : Ultimate ___ Complete ___ Basic ___

Add-ons (only with a package) ___________________________________

Deposit amount paid:$_______ Method of payment: ______________

Pre-Screening:

Do you have anything metallic implanted in your body? _________________

Do you have any of the following: (Y/N)

• Aneurysm clips • Bone growth stimulator • Cardiac defibrillator or pacemaker • Implanted drug infusion pump • Internal hearing aid • Neurostimulator/TENS unit/ Biostimulators • Transdermal drug patch	• Vascular clips or staples • Stents, Filters or Coils • Shunts • Implants or prosthesis • Greenfield IVC filter • IUD • Tattooed makeup

****If yes to any of these, we will evaluate for safety. List here:**_____________

____

Any history of surgery? _________ **Date:** ___________

Where and what? ____

Any allergies? _____ **To what?** ____

____

Pre-Scheduling:

Date to schedule, please check RIS for availability.

____

(see order and length of procedures form before checking availability to schedule)

Scheduled confirmation:

Confirmed scheduled DOS:

____

Confirmed scheduled blood draw:

____

***call mobile phlebotomy at 954-822-8501

Confirmed radiologist consult schedule date/time _______________

Confirmed patient has scheduling information. ____________________

Confirmed follow-up email sent

____