# MAX MRI IMAGING INC.

Fax – 818 382-2270
Scheduling – 800 851-4150

Patient Name:_____

Address:_____

Home Phone:_____ Cell Phone:_____

DOB:_____ SS#:_____

Referring Physician:_____ City:_____

Phone:_____ Fax:_____

Physician's Signature:_____

☐ STAT Wet Read ☐ CD ☐ Film ☐ Patient to Hand Carry

**MRI Request**

☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Brain

☐ Chest ☐ Pelvis ☐ Abdomen ☐ Elbow Right☐ Left☐

☐ Hip Right☐ Left☐ ☐ Knee Right☐ Left☐ ☐ Ankle Right☐ Left☐ ☐ Foot Right☐ Left☐

☐ TMJ Right☐ Left☐ ☐ Wrist Right☐ Left☐ ☐ Shoulder Right☐ Left☐ ☐ Hand Right☐ Left☐

☐ Other:_____

**CT Request – Please specify body part:**

**MRI Arthrogram Request – Please specify joint:**

**Billing Information**

☐ PI Lien ☐ Private Insurance ☐ Work Comp ☐ Other (specify):_____

Insurance:_____

Insuance Address:_____

Insurance Phone:_____ Date of Injury: _____

Claim #:_____ Adjuster:_____

Attorney:_____ Contact:_____

Attorney Address:_____

Phone:_____ Fax:_____

12264 El Camino Real #102
San Diego, 92130

336 Oxford St. #102
Chula Vista, 91911

3144 El Camino Real #107
Carlsbad, 92008

7711 Amigos Ave #C
Downey, 90241

17530 Ventura Blvd #106
Encino, 91316

8610 S. Sepulveda Blvd
Los Angeles, 90045

7774 Cherry Ave
Fontana, 92336

Temecula/Murrieta

**Fax Completed Form to 818 382-2270**