



361 Woodruff Rd  
 Greenville, SC 29607  
 Phone: 864-775-5004  
 Fax: 864-775-5012

APPOINTMENT DATE  
 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ AM / PM

# AMERICAN HEALTH IMAGING OF GREENVILLE

Please fax a copy of the patient's insurance information and any applicable clinical notes.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone/Home#: \_\_\_\_\_ Work/Other#: \_\_\_\_\_ Insurance Provider: \_\_\_\_\_  
 Ins. Group#: \_\_\_\_\_ Ins. Member#: \_\_\_\_\_ Precert/Auth#: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Physician Phone#: \_\_\_\_\_ Physician Fax#: \_\_\_\_\_

HEAD & NECK MRI		ORTHO MRI		BODY MRI		CT SCANS	
<input type="checkbox"/> WITHOUT CONTRAST		<input type="checkbox"/> WITH CONTRAST		<input type="checkbox"/> WITH&WITHOUT CONTRAST		<input type="checkbox"/> WITHOUT CONTRAST	
<input type="checkbox"/> WITHOUT CONTRAST		<input type="checkbox"/> IV ONLY (NO ORAL)		<input type="checkbox"/> ORAL AND IV			
<input type="checkbox"/> Brain	<input type="checkbox"/> Finger/Thumb L R	<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> Brain	<input type="checkbox"/> Extremities L R	<input type="checkbox"/> Facial Bones	Specify: _____	
<input type="checkbox"/> Volumetric Study	<input type="checkbox"/> Hand L R	<input type="checkbox"/> MRCP	<input type="checkbox"/> Sinuses	<input type="checkbox"/> CTA Pulmonary	<input type="checkbox"/> Sinus Stealth	<input type="checkbox"/> CTA - Abdomen/Pelvis (AAA)	
<input type="checkbox"/> DTI	<input type="checkbox"/> Wrist L R	<input type="checkbox"/> Chest	<input type="checkbox"/> Sinus Stealth	<input type="checkbox"/> CTA Chest - Aneurysm	<input type="checkbox"/> IAC's	<input type="checkbox"/> CTA Head	
<input type="checkbox"/> IAC'S	<input type="checkbox"/> Elbow L R	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pituitary	<input type="checkbox"/> CTA Neck	<input type="checkbox"/> Pituitary	<input type="checkbox"/> Cervical Spine	
<input type="checkbox"/> Pituitary-Sella	<input type="checkbox"/> Shoulder L R	<input type="checkbox"/> Enterography	<input type="checkbox"/> Orbits	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Orbits	<input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> Orbits	<input type="checkbox"/> Scapula L R	<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Chest	
<input type="checkbox"/> TMJ	<input type="checkbox"/> Foot L R	<input type="checkbox"/> Pelvis (bony)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Renal (wo/w IV)	
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Ankle L R	<input type="checkbox"/> Pelvis (soft tissue)	<input type="checkbox"/> Liver	<input type="checkbox"/> Liver (wo/w IV)	<input type="checkbox"/> Abdomen/Pelvis Enterography	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Cranial Nerves	<input type="checkbox"/> Knee L R	<input type="checkbox"/> Liver	<input type="checkbox"/> SPINE MRI	<input type="checkbox"/> Urogram	<input type="checkbox"/> Abdomen/Pelvis Kidney Stone	<input type="checkbox"/> Other _____	
<b>MRA</b>	<input type="checkbox"/> Hip L R	<input type="checkbox"/> Cervical	<input type="checkbox"/> Circle of Willis (Head)	<input type="checkbox"/> Thoracic/Dorsal	<input type="checkbox"/> Enterography w/IV		
<input type="checkbox"/> Circle of Willis (Head)	<input type="checkbox"/> Thigh L R	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Carotids/Vertebrae	<input type="checkbox"/> Lumbar			
<input type="checkbox"/> Carotids/Vertebrae	<input type="checkbox"/> Lower Leg L R	<input type="checkbox"/> Other _____	<input type="checkbox"/> Renal	<input type="checkbox"/> Other _____			

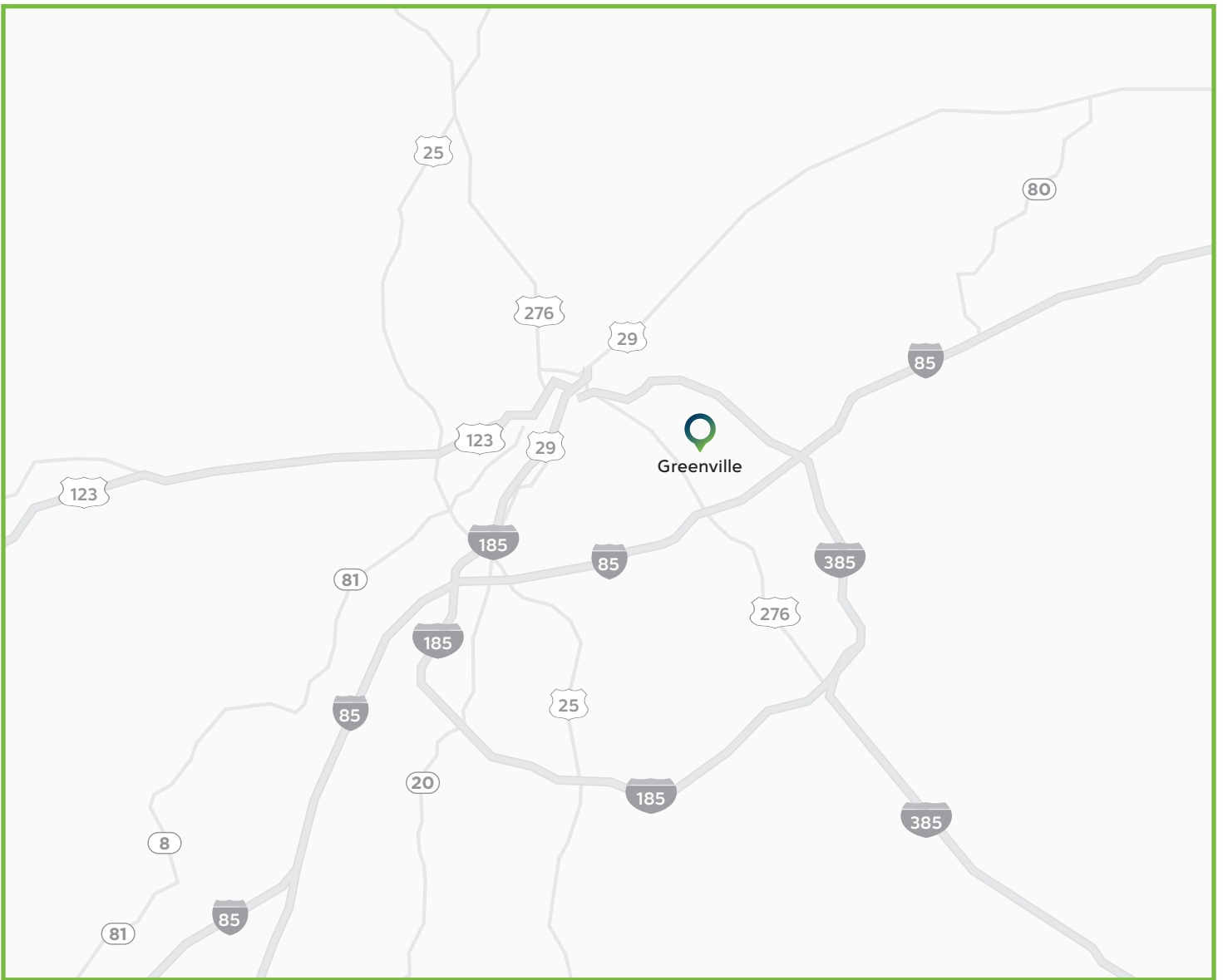
## ATTORNEYS

Attorney Name: \_\_\_\_\_ Attorney Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
 Work Comp  MVA  Slip & Fall

Report Only  CD  Images w/PT  STAT

ICD-10 Code / Diagnosis: \_\_\_\_\_  
 Special Instructions: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FREE PARKING • SAME DAY APPOINTMENTS • NEXT DAY RESULTS



## STATE-OF-THE-ART DIAGNOSTIC IMAGING AVAILABLE IN GREENVILLE

361 Woodruff Road  
Greenville, SC 29607  
Phone: 864-775-5004  
Fax: 864-775-5012  
[AmericanHealthImaging.com](http://AmericanHealthImaging.com)