Scheduling Form

Southwest corner of 7th Ave. and Glendale

701 W. Glendale Ave.
Phoenix, AZ 85021
Tel: (602) 294-9009
Fax: (602) 294-9012

We Provide Authorizations
Please Provide:

Front and back of insurance card
Fax appropriate physician notes

PATIENT INFORMATION

Patient Name: ______________________ DOB: ______________

Phone (H) (   ) ______________ (C) (   ) ______________ (W) (   ) ______________

Insurance Co.: ______________________ Ins. Auth. # ______________

If attorney lien, name of attorney: ______________________ Phone: (   ) ______________

PHYSICIAN INFORMATION

Referring Physician ***(please print)*** ______________________

Referring Physician signature: ______________________

Name of person scheduling appointment: ______________________

Office Phone: (   ) ______________ Office Fax: (   ) ______________

MRI EXAM INFORMATION

MRI Exam Requested: ______________________

☐ With and/or without contrast per radiology protocols.

☐ Please check box if contrast cannot be administered.

Diagnosis/Clinical History: ______________________

ICD-9 Code(s): ______________________

Appointment Date:

Appointment Time:

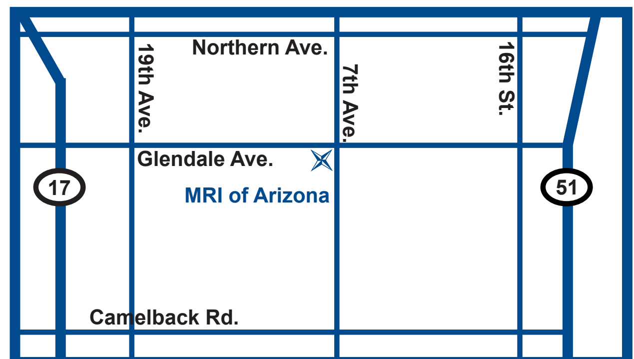
REPORT INSTRUCTIONS

☐ Deliver films with report to: ______________________

☐ CC report to: ______________________

☐ Report only ______________________

☐ Hand carry films ______________________



Free Transportation
Liens Accepted
Bilingual Staff
Same Day Scheduling