15528 West Colonial Drive
Winter Garden, FL 34787

VIP Scheduling: 407-674-9600

MARC IMAGING GROUP
WINTER GARDEN

Tax ID#
93-2901372

Fax: 407-557-9404

Patient Name: _____
FIRST M. LAST

Driver's License # or Last 4 of SS: _____ Patient Phone: _____

DOB: _____ Diagnosis: _____

Auto Insurance: _____ Claim #: _____

Date of Accident: _____ ☐ Patient Demographics/Intake Form Attached ☐ EMC

Representing Attorney: _____ Address: _____

MRI (Head)

- ☐ Routine Brain (including Brain Stem)
- ☐ DTI (Traumatic Brain Injury)
- ☐ TMJ
- ☐ Special Instructions: _____

MRI (Spine)

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/Coccyx
- ☐ Other: _____

MRI (Lower Extremities/Joints)

☐ Hip	☐ R	☐ L
☐ Femur	☐ R	☐ L
☐ Knee	☐ R	☐ L
☐ Tib/Fib	☐ R	☐ L
☐ Ankle	☐ R	☐ L
☐ Forefoot	☐ R	☐ L
☐ Hindfoot	☐ R	☐ L

☐ Special Instructions: _____

MRI (Orbit/Face/Neck)

- ☐ Face
- ☐ Orbits
- ☐ Bracial Plexus - Upper Extremity
- ☐ Other: _____

MRI (Upper Extremities/Joints)

☐ Shoulder	☐ R	☐ L
☐ Humerus	☐ R	☐ L
☐ Elbow	☐ R	☐ L
☐ Forearm	☐ R	☐ L
☐ Wrist	☐ R	☐ L
☐ Hand	☐ R	☐ L

☐ Other: _____

X-Ray

☐ Skull	☐ Shoulder	☐ R	☐ L
☐ Cervical	☐ Knee	☐ R	☐ L
☐ Thoracic	☐ Ankle	☐ R	☐ L
☐ Lumbar	☐ Foot	☐ R	☐ L

☐ Other: _____

Clinical Indications: _____

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone: _____ Fax: _____

Doctor's Signature: _____ Date: _____