SRINI MALINI, MD, PA

PATIENT INFORMATION 2009-2010 **TODAY'S DATE**: ____________________

PATIENT'S NAME: ____
First Middle Last

MARITAL STATUS (circle one) Married Single Divorced Widowed Other

PATIENT'S DATE OF BIRTH: _________________________ AGE ______ YRS
Month Day Year

ADDRESS: ____ FOR HOW LONG? _______

CITY: ________________________ STATE: __________ ZIP CODE: _____________

TELEPHONES: ( ) _____________ ( )_________________( )_____________
Home Phone Work Phone Cell Phone

E-MAIL: _________________@ ___________________Day Phone( ) ____________

PATIENT'S EMPLOYER: ____
Name Address Phone

PATIENT'S OCCUPATION: ______________ SPOUSE'S OCCUPATION: _____________

SPOUSE'S NAME: ____
First Middle Last

SPOUSE'S EMPLOYER: ____
Name Address Phone

SPOUSE'S DATE OF BIRTH: _________________________
Month Day Year

NAME OF INSURED: ____________________ Please give a copy of the insurance card

____
NAME, PHONE NUMBER & RELATIONSHIP OF PERSON TO NOTIFY IN EMERGENCY

FOR IDENTIFICATION PURPOSES, PLEASE PROVIDE:

PT'S DRIVER'S LIC NO: _______________ SPOUSE'S DRIVER'S LIC NO:____________

REFERRED TO DR. MALINI BY PHYSICIAN:
Your Doctor's Full Name and Phone Number: ____________________________

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The Consent and Authorizations in this page are good for one year.

Consent for Treatment at Srini Malini, MD, PA

I consent to treatment by SRINI MALINI, MD (a Board Certified Radiologist) and her staff under her direction.

Authorizations for Payment

I authorize payment of medical benefits to SRINI MALINI, MD, PA for services provided.
I authorize the release of any medical or other information necessary to process the claim through my insurance company.
If applicable, I request payment of government benefits to Srini Malini, MD, PA for Medicare or other government benefits.

Acknowledgement of Notice of Privacy Practices

I have reviewed HIPAA Notice of Privacy Practices of the offices of SRINI MALINI, MD, PA, which explains how my medical information will be used and disclosed. The privacy information is also posted on the practice website at www.malini.net/Privacy.html.

I agree to the above consent, authorizations and notice in this page.

______________________________________ ________________
Signature of Patient or Personal Representative Date

____
Full Name of Patient or Personal Representative

Name (print):_________________________________**DOB**:___________ **Date**: ___________

Is there a chance that you are pregnant? Yes No
Have you had a barium X-ray in the last 2 weeks? Yes No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No
Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

1. Your: Age: ____ Sex: Male Female Height: ft in Weight: lbs

2. Your ethnicity (check one – this info is needed for bone density evaluation):
__Caucasian (White) __Black __Asian __Hispanic __Other
Your country of birth: ______________________

3. Have you ever had a bone density test? Yes No
If YES, when and where? ____
I understand **Medicare** will pay only once in **24 months** for the bone density.

4. Have you had a recent weight change? Yes No
If YES, tell us about it: ____

5. Your tallest height (late teens or young adult): ______________

6. Have you ever broken a bone? Yes No

Bone broken	Simple fall?	If not a simple fall, please describe the circumstances	Age when this occurred

7. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

9. How many times have you fallen in the last year? ________

10. Have you ever had surgery of the spine, hips, legs or arms? Yes No
If YES, describe what type of surgery you had and which side was affected
____
____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?
Yes, currently ____ Yes, previously _____ No ____
If YES, for how long? ________ What is your dose? _____mg or ______ pills each day

12. List any chronic medical conditions that you have:
__________________________________ __________________________________
__________________________________ __________________________________

13. Do you smoke? Yes No
14. Do you take any calcium supplements (including TUMS)? Yes No

15. Are you ____RIGHT-HANDED ____ LEFT-HANED

16. Are you currently receiving or have you previously received any of the following medications?

	No	Yes	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

17. Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Zometa)			
Sodium fluoride (Fluotic)			

18. How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	Orange juice fortified with calcium (full cup)	Yogurt (small container or ½ cup)	Cheese
Number of servings				

19. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

For women only…

20. Are you still having menstrual periods? Yes No

21. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

22. Have you had your menopause? Yes No
If yes, at what age? ____________

23. Have you had a hysterectomy? Yes No
If YES, at what age? ________
Have you had both of your ovaries removed? Yes No
If YES, at what age? _________

NAMES OF DOCTORS TO SEND REPORTS TO.__________________________________

PHONE NUMBER(S) OF DOCTORS TO SEND REPORTS TO:

I WANT A COPY OF THE REPORT ALSO TO BE SENT TO ME (circle) Yes No

Name (print):__________________________ For Office Use ---MEDISOFT ID #:

SRINI MALINI, MD, PA

Ultrasound, Mammography & DXA Bone Density
8200 Wednesbury Lane, Suite 320
Houston, Texas 77074
Phone: 713-795-5672
Fax: 713-795-5809

Authorizations for Release of Films, CD/DVD Images, Results & Reports

Patient's Name	
Date of Birth	
Today's Date	
Referring Physician	

To____

I authorize release to DR. SRINI MALINI, a Board Certified Radiologist.

☐ My **CD or DVD with DICOM Images** for **DIGITAL MAMMOGRAMS** and **MAMMOGRAM FILMS** for screen-film and REPORTS FOR COMPARISON.

☐ **Breast Ultrasound** films if done. **CD or DVD of DICOM ultrasound images** is requested.

☐ My **BREAST BIOPSY** or **BREAST SURGERY** Results

☐ My **SURGERY & PATHOLOGY** Reports for –circle **NECK ABDOMEN PELVIS**
Please do not send Pathology Slides. Dr. Malini is a radiologist and only needs the reports.

☐ **Blood Chemistry** for – circle – Parathyroid Thyroid OB Gyn Abdomen

☐ My **DXA Bone Density Data** with detailed Reports for comparison.

☐ **Other**

A Facsimile or Photostat of this authorization shall be considered as effective and valid as the original.

Signed ____

Date ____

www.malini.net