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: ____________________________

____

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

SRINI MALINI, MD, PA **MEDICAL INFO**

Patient's Name:_____________________________ Age:_________ Date:__________

Please circle those that you now have:

AIDS	Diabetes	Jaundice	Stomach Trouble
Abdominal Pain	Endometriosis	Kidney Infection	Thyroid Problems
Anemia	Gallbladder Disease	Kidney Trouble	Ulcer
Bleeding	Heart Trouble	Pelvic Infection	Other
Cancer	High Blood Pressure	Pelvic Pain	

IF OTHER, PLEASE EXPLAIN: ____
____

SURGERY: WHAT TYPE OF SURGERY HAVE YOU UNDERGONE?

WHEN?	HOSPITAL/CLINIC	OPERATION	BY WHOM?

What were the results of any surgery or laparoscopy of your abdomen or pelvis?_______

____

Why did your doctor send you for ultrasound today?______________________________

____

What medication(s) are you now taking?____

____

Have you had an **ultrasound examination** before? Yes No

If yes, when?______________________ Where?______________________________

For what reason?___________________ Results?_____________________________

Do you consume alcohol? (circle) Yes: Mildly Moderately Heavily No

Do you smoke? Yes: Amount per day______________ No

Current weight___________ Height____________

Have you lost weight? Yes: How much?_____________ No Dieting

Any other pertinent medical information:_______________________________________

SRINI MALINI, MD, PA **GYN and OB info** **FOR WOMEN ONLY**

Patient's Name:_______________________________ Age:_________ Date:____________

Menstrual history: (circle) Regular Irregular Flow: Light Heavy

I menstruate every ______ days For how many days?_______ Cramps or Pain?__________

Last menstrual period_____________

Are you on birth control pills? (circle) Yes No

If yes, for how long?_______________ When did you discontinue the pills?_____________

Do you have an IUD? (circle) Yes: What type?__________________ No ______

Date IUD was removed:____

Have you had an X-ray dye test of the uterus (hysterosalpingogram)? Yes _____No ______

If yes, when?_______________ Where?_______________ Results?___________________

Other comments:____

Please list all pregnancies, miscarriages, and/or terminations:

Birth date	Where?	By Dr.	Weight	Gender	Type of Delivery	Complications

Expected delivery date _________________

Date of last pregnancy test_______________ Results? (circle) Positive Negative

What type of test did you have? (circle) Blood Urine HCG level _____________

Have you been on Clomid or any fertility drug in this pregnancy? _______________________

Did you go to your doctor for a routine check-up or for a medical problem?_______________

Did you have an amniocentesis CVS NT Serum/Blood testing?____________________

Do you have pain? (circle) Yes No Where is the pain?_________________________

Please list birth defects in family, if any :____

At which hospital do you plan to deliver the baby?___________________________________

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