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

ACR MAP 01716 **SRINI MALINI, MD, PA**

Breast History 2009-10 Ultrasound, Digital Mammography & Bone Density 713-795-5672

Patient's Name:	**Age**:	**Date**:

Have you ever had a mammogram before? Yes No If yes, give the name & address of the Clinic or Hospital **Date(s) of previous mammograms**
Results Normal Abnormal Other
What is the **reason** for today's mammogram? (please circle) Lump-R Lump-L Pain Discharge Routine Implants Other How Long?
If you are referred because of lump (s) in your breast (s) are the lump (s) smaller, larger, or disappeared?
Have any of your blood relatives ever had breast cancer? Yes No If YES, relationship: Mother Sister Grandmother Aunt At what age(s)?
Are they maternally or paternally related to you?
At what age did your start your first menstrual cycle? years
Date of **Last Menstrual Period** **Are You Pregnant?**
If hysterectomy, date of surgery
Are you taking hormones? Yes No What Hormones?
Are your on birth control pills? Yes No
How long have your been on hormones or BCP?
Please list all prescription medications your are taking
Did you breast feed your children? Yes No Number of children
How long did you breast feed? Any complications from breast feeding ? Yes No
Have you ever had an injury or infection to your breast? Yes No
If yes, please give details and date this occurred
Have you ever had **breast surgery**? Yes No Please check procedure
Biopsy☐ **Aspiration**☐ **Lumpectomy** ☐ **Mastectomy** ☐ **Reduction**☐ ☐ **Other**
Date of procedure
If yes, name of the doctor, hospital or clinic, & results of previous surgery - what abnormality was found?
Do you have Implants? Yes No What kind? Silicone Saline Explanted
What, where, by whom, and details of **Implan**t surgery
Do you have diabetes, arthritis, **cancer** or any other medical problem? Yes No
Any other information or comments:
Doctors to whom you wish to send the Mammogram Report
Phone Number(s) and Address of Doctor(s) to Send Report to:
You will receive a Results Report as required by Federal Law

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 _____