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 OB & Medical 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 **SURGERY & PATHOLOGY** Reports for –circle

OBSTETRICS PELVIS ABDOMEN THYROID OTHER

Please do not send Pathology Slides. Dr. Malini is a radiologist and only needs the the delivery, surgery and pathology reports.

☐ **Blood work** for – circle – Obstetrics Gyn Thyroid Abdomen

☐ Results of the present pregnancy when completed

Baby's Date of Birth — Baby's birth weight
Type of Delivery — Any birth defects?
Any maternal complications? — Any fetal complications?

☐ **Name of pediatrician** who will care for this baby.

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

Signed _____

Date _____