DIAGNOSTIC IMAGING CENTERS, P.A.

Breast Imaging Exam Form

Tech Initials: ___________

MRN #: _____________

PATIENT INFORMATION

Name: _______________________________ Date of Birth: __________ Age: ___ Date of last mammogram: __________

Reason for today's exam: ❑ First mammogram ever ❑ Annual mammogram

New symptoms may require Doctor's order ❑ New symptom/problem ❑ 6-month follow-up

*Describe your *new* breast problem and how long you have had it (if applicable): _________________________________

____

MEDICAL INFORMATION AND RISK ASSESSMENT

FAMILY HISTORY

1. Has anyone in your **Family** been diagnosed with **breast** cancer? ❑ Yes ❑ No

✓ If *Yes* , please check the relative and age at time of diagnosis:

❑ Mother/Age____ ❑ Daughter/age____ ❑ Sister/age___

❑ Aunt/Age____ → ❑ Maternal ❑ Paternal

❑ Grandmother/Age____ → ❑ Maternal ❑ Paternal

PERSONAL HISTORY

1. Race: ❑ White ❑ African American ❑ Hispanic ❑ Unknown ❑ Asian-American ❑ American Indian/Alaskan Native

2. Ethnicity (If applicable): ❑ Chinese ❑ Japanese ❑ Filipino ❑ Hawaiian ❑ Other Pacific Islander ❑ Other Asian-American

3. Have ***you*** previously been diagnosed with **breast** cancer? ❑ Yes ❑ No

4. Do ***you*** have a history of **female** cancer? *(Ovarian, uterine, cervical)* ❑ Yes ❑ No

5. Known BRCA1 or BRCA2 mutation or similar genetic syndrome? ❑ Yes ❑ No

6. Do you take hormones? ❑ Yes ❑ No

✓ If *Yes* , please check the ones you are currently using: ❑ Birth control ❑ Estrogen ❑ Progesterone Evista ❑ Tamoxifen ❑ Arimidex ❑ Testosterone

Length of time on hormones: ______ ❑ Months ❑ Years

7. Age at ***first*** menstrual period? ❑ Age 7-11 ❑ Age 12-13 ❑ Age 14 or older

8. Date of your *last* menstrual period: _________________

9. Are you **post menopausal?** ❑ Yes ❑ No

10. Are you pregnant? ❑ Yes ❑ No

11. Age when you had your first child? ❑ No Births ❑ Under 20 ❑ Age 20-24 ❑ Age 25-29 ❑ Age 30 + ❑ Unknown

BREAST PROCEDURES

1. History of breast biopsy? ❑ Yes ❑ No ❑ Rt ❑ Lt Date(s):____________

✓ If *Yes* , how many times? ❑ 1 ❑ More than 1

Did any of the biopsies show *atypical* hyperplasia? ❑ Yes ❑ No
(or other high risk marker on biopsy?)

2. History of mastectomy? ❑ Yes ❑ No ❑ Rt ❑ Lt ❑ Bilateral Date: __________

3. History of lumpectomy? ❑ Yes ❑ No ❑ Rt ❑ Lt ❑ Bilateral Date: __________

4. Treatment: ❑ Chemotherapy ❑ *with* radiation ❑ *without* radiation

5. History of breast reduction surgery? ❑ Yes ❑ No Date: _____________

6. History of breast implant surgery? ❑ Yes ❑ No Date: _____________

Patient Signature: ____ Date: _____________

DIAGNOSTIC IMAGING
CENTERS, P.A.

MOBILE MAMMOGRAPHY

Medical Records Release

Patient Name: ______________________________
MRN: ________________ DOB: ________________
Exam: ____________________________________
Referring Provider: ____________________________

DIC Location: _______________ Date: ___________
____
____

Patient's Prior Last Name (If Applicable): ____ ❑ N/A

Please provide the following information so that we may obtain your latest mammogram and/or other breast imaging records for comparison.

Name of Facility: ____
Address of Facility: ____
City/State/Zip: ____
Phone/Fax: ____

I hereby authorize and request you to release all breast imaging, including copies of reports in your possession to Diagnostic Imaging Centers, P.A.

___________________________	X___________________________	___________
Please print name	Patient or authorized signature	Date

REPORTS: Please fax reports to our Mobile Mammography Department at (913) 955-3744.
If you need to speak to one of our Mobile Mammography Team Members, you can reach them at (913) 222-9758 or (913) 602-6692.

IMAGES: If you are unable to cloud images, please mail CD to our Medical Records department.

Diagnostic Imaging Centers, P.A.
6650 W. 110th St. Suite 100
Overland Park, KS 66211

Thank you!

DIAGNOSTIC IMAGING CENTERS, P.A.

Patient Registration Form

Patient Name: ___________________________________

MRN: __________________ DOB: __________________ DIC Location: _________________ Date: ____________

Exam: ____ ____

Referring Provider: ______________________________ ____

PATIENT INFORMATION

Age: ________________ ❑ Male ❑ Female SSN #: ________________________________

Address: ____________________________________ City: ___________________________ State: _____ Zip: _________

Home Phone: _________________ Daytime Phone: __________________ Email Address: _________________________

_________ ***By placing my initials in the space provided, I verify that I have reviewed the information above and it is correct.***

GUARANTOR INFORMATION

Relationship to Patient: ____________________________ Name: ____

Address: ____________________________________ City: ___________________________ State: _____ Zip: _________

PRIMARY INSURANCE INFORMATION

Plan: ____ Policy #: ____

Group #: _______________________________________ Insured's Relationship to Patient: __________________________

Name of Insured: _______________________________ SSN of Insured: ________________ DOB of Insured: _________
(If other than Patient)

SECONDARY INSURANCE INFORMATION

Plan: ____ Policy #: ____

Group #: _______________________________________ Insured's Relationship to Patient: __________________________

Name of Insured: _______________________________ SSN of Insured: ________________ DOB of Insured: _________
(If other than Patient)

ACKNOWLEDGEMENT / WAIVER OF LIABILITY

Please initial by each statement below:

1. _______ I hereby authorize and request payment to Diagnostic Imaging Centers, P.A. for any Medical Benefits due under the terms of my insurance policy for services rendered. I further authorize the release of all necessary information including reports, images and outcomes as requested by my Insurance Carrier(s).

2. _______ I have been informed by Diagnostic Imaging Centers, P.A. that my procedure may not be a covered service. I understand that charges for all services provided but not covered by my insurance will be my financial responsibility.

3. _______ I authorize the release of all or any portion of my medical record to any health care practitioner or facility designated by me.

____ ______________________

Patient or Parent (If Minor) Signature ***Date***

DIAGNOSTIC IMAGING
CENTERS, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Diagnostic Imaging Centers Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren’t able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____

____

____

______________________________ ____________________

Employee signature *Date*