PATIENT REGISTRATION INFORMATION

Today's Date: _____/_____/_____ Referring Physician: ___________________________

Patient Information

Last name: _______________________ First name: _________________________ Middle Initial: ____

Social Security # _____________________ Sex: Male ( ) Female ( ) Date of Birth: _____/_____/_____

Address: ____ Apt # ______________

City, State, ZIP Code: ____

Home Phone # ______________________________ Alt. /Cell # ______________________________

Emergency Contact: Name _____________________________ Relationship___________________

Home Phone # ______________________________ Alt. /Cell # ______________________________

Patient's Employment: Full Time____ Part Time ____ Retired ____ Not Employed ____ Student____

Employer: _____________________________________ Work phone # _________________________

Address: ____

Primary Insured: _____ Self (Skip to Primary Insurance Section)

Name & Relationship to Patient: ____________________________ Date of Birth: _____/_____/_____

Primary Insurance: ____

Policy # ______________________________________ Group # ____________________________

Secondary Insurance: ____

Policy # ______________________________________ Group # ____________________________

2003–A Whitesburg Drive, Huntsville, AL 35801 –Phone (256) 536-3550 Fax (256) 536-3554

PATIENT AGREEMENT AND ACKNOWLEDGEMENT FORM

I understand payment of all insurance benefits for this period of service must be made directly to The Center of Imaging Excellence. If a check must be made out to me, I understand that the check must be sent to The Center of Imaging Excellence at the address listed at the bottom of this page.

Initial __________

I understand The Center of Imaging Excellence must collect for all the charges not covered by insurance payment. Payment for all collection costs is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

Initial __________

I hereby consent to The Center of Imaging Excellence to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetics as necessary and any other general medical/emergency treatment and hospital care considered advisable or necessary by the physician.

Initial __________

Acknowledgement to use and disclose health information for treatment, payment, or healthcare operations (HIPAA pamphlet available on the front desk counter). I understand and have been offered a copy of the Privacy Practices of The Center of Imaging Excellence.

Initial __________

I have read and do understand the above statements and I have willingly signed.

______________________________ ______________

Signature of the Patient / Guardian Date

Fall Precaution Y N

Patient Sticker

PATIENT INFORMATION

Last Name	First Name/Middle Initial	DOB	Age	Race
		/ /		

Is today's evaluation your first mammogram: _____ yes _____ no

If not, year and location of your last mammogram_______________

Year of your last breast exam performed by a healthcare professional_______________

CURRENT SYMPTOMS

	Which breast?	Duration?
Lump:	L / R	______
Nipple inversion:	L / R	______
Discharge:	L / R	______
Color of discharge: ______		
Skin retraction:	L / R	______
Tenderness :	L / R	______

Other symptoms: _______________

____

HORMONE HISTORY

Date of your last menstrual period: __________

Have you ever taken hormones?: ___no ___yes

If yes, list type (birth control pills, hormone replacement, etc) and dates of use:

____

____

____

Breast fed in the last six months? ___no ___yes

Currently breast feeding? ___no ___yes

Weight changed by more than 15 lbs since your last mammogram? ___no ___yes

If yes, please specify:_______________

BREAST SURGICAL & BIOPSY HISTORY

Breast reduction: ___no ___yes if yes, year _____

Implants: ___no ___yes if yes, year _____

Please list any previous benign breast surgeries or biopsies, including which breast and the approximate year:

____

____

____

BREAST CANCER HISTORY

Have you ever had breast cancer? ___no ___yes

If yes, please answer the following:

Which breast? ___ right _____ left

Year of diagnosis: __________

Type of surgery: ___lumpectomy ___mastectomy

Did you have chemotherapy?: ___no ___yes

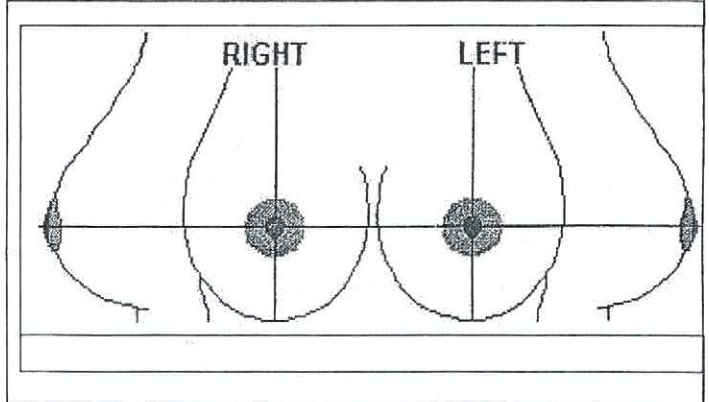
Did you have radiation?:_ ___no ___yes

Name of surgeon: __________

Name of medical oncologist: __________

Name of radiation oncologist: __________

FOR TECHNOLOGIST USE ONLY



TECHNOLOGIST COMMENTS

____

TECHNOLOGIST SIGNATURE, DATE & TIME

THE CENTER OF IMAGING EXCELLENCE

Personal and Family History Questionnaire

Date Completed: ______________________________

Patient Label

What was your age at the time of your first menstrual period? _____

Have you been pregnant before? ____ yes ____no If yes, please provide your age at delivery of your first child: ____

Instructions: Please circle **Y(yes)** or **N(no)** to those that apply to **YOU** and/or **YOUR FAMILY** (on your mother or father's side) to the best of your knowledge. In the spaces provided, please list the relationship to you and the age of diagnosis.

		Breast Cancer Risk Assessment	Relationship(s) to you	Age(s) at Diagnosis
Y	N	Have YOU had breast cancer?		
Y	N	Do you have a family history of breast cancer in your **mother, daughter, or sister(s)**?		
Y	N	Have your **father** or **brother** had breast cancer?		
Y	N	Have **you or any blood relative** tested positive for BRCA1 or BRCA2 genetic mutations?		
Y	N	Did YOU have radiation treatments to the chest between the ages of 10 and 30 for treatment of **cancer** such as lymphoma?		
Y	N	Do YOU have a history of atypical lobular hyperplasia, atypical ductal hyperplasia, or lobular carcinoma in situ?		

		Additional Information	Relationship(s) to you	Age(s) at Diagnosis
Y	N	Do you have a family history of breast cancer in other relatives such as grandmothers or aunts (please specify paternal or maternal)?		

Patient Signature **Date** **Technologist Signature** **Date**