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: ____/____/____

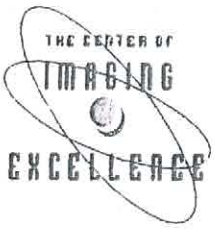
Primary Insurance: _____

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

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

The Center of Imaging Excellence

Women's Center

2003-A Whitesburg Dr. Huntsville, AL 35801
Phone 256-536-3550 Fax 256-536-3554

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:

_____

_____

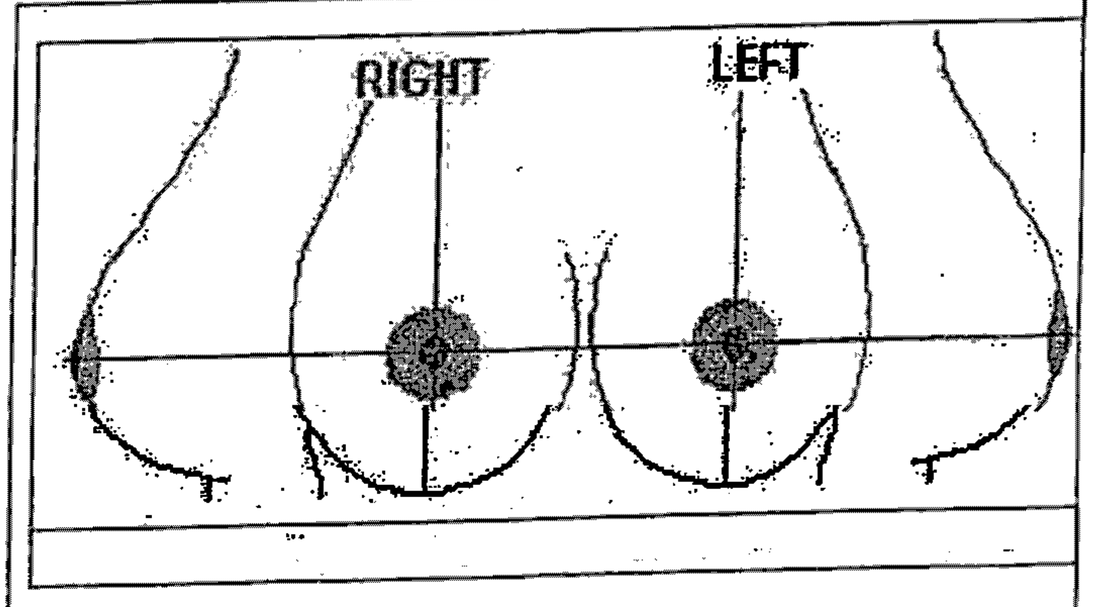
_____

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 & Family History Questionnaire

PATIENT INFORMATION

Last Name	First Name/Middle Initial	**Date of Birth** (MM/DD/YYYY)

PERSONAL HISTORY

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 the delivery of your first child: _____

BREAST CANCER RISK ASSESSMENT

Instructions: Please check **Yes or 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.

Have **YOU** had breast cancer?	□ YES □ NO		Age(s) at Diagnosis:
Do you have a family history of breast cancer in your **mother, daughter, or sister(s)?**	□ YES □ NO	Relationship(s) to you:	Age(s) at Diagnosis:
Has your **father** or **brother** had breast cancer?	□ YES □ NO	Relationship(s) to you:	Age(s) at Diagnosis:
Have **you or any blood relative** tested positive for BRCA1 or BRCA2 genetic mutations?	□ YES □ NO	Relationship(s) to you:	Age(s) at Diagnosis:
Did YOU have radiation treatments to the chest between the ages of 10 and 30 for treatment of **cancer** such as lymphoma?	□ YES □ NO		Age(s) at Diagnosis:
Do YOU have a history of atypical lobular hyperplasia, atypical ductal hyperplasia, or lobular carcinoma in situ?	□ YES □ NO		Age(s) at Diagnosis:
Do YOU have a family history of breast cancer in other relatives such as **grandmothers or aunts** (please specify paternal or maternal)?	□ YES □ NO	Relationship(s) to you:	Age(s) at Diagnosis:

TECHNOLOGIST COMMENTS

_____ _____

PATIENT SIGNATURE **DATE** **TECHNOLOGIST SIGNATURE** **DATE**