

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 Srin 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 Srin 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

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
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  _____