

# 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](http://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

<b>Patient's Name:</b>		<b>Age:</b>	<b>Date:</b>
Have you ever had a mammogram before?      Yes                      No			
If yes, give the name & address of the Clinic or Hospital			
<b>Date(s) of previous mammograms</b>			
Results	Normal	Abnormal	Other
What is the <b>reason</b> for today's mammogram? (please circle)			Lump-R      Lump-L
Pain	Discharge	Routine	Implants      Other      How Long?
If you are referred because of lump (s) in your breast (s) are the lump (s) smaller, larger, or disappeared?			
Have any of your blood relatives ever had breast cancer?		Yes	No
If YES, relationship:      Mother      Sister      Grandmother		Aunt	At what age(s)?
Are they maternally or paternally related to you?			
At what age did you start your first menstrual cycle?		years	
<b>Date of Last Menstrual Period</b>		<b>Are You Pregnant?</b>	
If hysterectomy, date of surgery			
Are you taking hormones?		Yes	No      What Hormones?
Are you on birth control pills?		Yes	No
How long have you been on hormones or BCP?			
Please list all prescription medications your are taking			
Did you breast feed your children?		Yes	No      Number of children
How long did you breast feed?		Any complications from breast feeding ?      Yes      No	
Have you ever had an injury or infection to your breast?		Yes	No
If yes, please give details and date this occurred			
Have you ever had <b>breast surgery</b> ?		Yes	No      Please check procedure
<b>Biopsy</b> <input type="checkbox"/>	<b>Aspiration</b> <input type="checkbox"/>	<b>Lumpectomy</b> <input type="checkbox"/>	<b>Mastectomy</b> <input type="checkbox"/> <b>Reduction</b> <input type="checkbox"/>
<b>Other</b>			
<b>Date of procedure</b>			
If yes, name of the doctor, hospital or clinic, & results of previous surgery - what abnormality was found?			
<b>Do you have Implants?</b>		Yes	No      What kind?      Silicone      Saline
Explanted			
What, where, by whom, and details of <b>Implant</b> surgery			
Do you have diabetes, arthritis, <b>cancer</b> or any other medical problem?		Yes	No
<b>Any other information or comments:</b>			
<b>Doctors to whom you wish to send the Mammogram Report</b>			
Phone Number(s) and Address of Doctor(s) to Send Report to:			
You will receive a Results Report as required by Federal Law			

**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  \_\_\_\_\_