

# ZILKHA RADIOLOGY

Long Island Magnetic Resonance Imaging, P.C.

Long Island Medical Imaging, P.C.

Long Island Medical Diagnostic Imaging, P.C.

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WEST ISLIP, NY 11795  
(631) 669-1717 /FAX (631) 669-2227

## BREAST IMAGING

Today's Date \_\_\_\_\_ Time of Appointment \_\_\_\_\_ Time of Arrival \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ **Male** **Female**

Street \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Telephone # \_\_\_\_\_ Mobile # \_\_\_\_\_

Employer \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder (If not yourself) \_\_\_\_\_ Relationship **Spouse** **Parent** **Dependent** **Other**

Policy Holder's: Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship **Spouse** **Parent** **Dependent** **Other**

Referring Doctor Name & Phone # \_\_\_\_\_

Other Doctor's you want your results sent to: \_\_\_\_\_  
(Name, Town & Phone Number)

**AUTHORIZATION FOR TREATMENT:** I hereby consent to treatment by the radiologist and other medical staff for all tests and/or procedures by Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C.

**Patient or Legal Guardian Initial** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby assign Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. to release any information acquired in the course of my examination and treatment to my insurance company.

**Patient or Legal Guardian Initial** \_\_\_\_\_

**AUTHORIZATION OF PAYMENT:** I hereby assign payment to Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. for the medical benefits due under the terms of my insurance policy. I fully understand that I am financially responsible for my deductible, co-payment, co-insurance, and charges not covered by my health insurance plan.

**Patient or Legal Guardian Initial** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES (HIPAA) & RELEASE OF MEDICAL RECORDS:** I acknowledge that I have been provided with a copy of Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. (the Practice's) Notice of Privacy Practices. I authorize release of my films/images, reports and/or medical records to my referring doctor, and any other doctor listed above. I authorize the persons listed below to discuss or retrieve any information pertaining to my treatment. (Photo ID required)

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

I hereby authorize a photo copy of this form to be valid as the original. This authorization will remain in effect unless changed by myself. I have read and understand the above, and agree to the terms listed above.

**Patient or Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

What is the reason for your exam today?

**YES NO** First Mammogram/Baseline **YES NO** Annual Exam

**YES NO** Follow-up exam Explain \_\_\_\_\_

Date of Last Mammogram \_\_\_\_\_ Place \_\_\_\_\_  
(It is the responsibility of the patient to bring prior mammograms from other facilities for comparison purposes)

Date of Last Clinical Breast Exam \_\_\_\_\_ Results \_\_\_\_\_

Are you currently having any breast problems?

**YES NO** Pain/Tenderness **Right Left** Duration \_\_\_\_\_

**YES NO** Lump/Thickening **Right Left** Duration \_\_\_\_\_

**YES NO** Discharge/Bleeding **Right Left** Duration \_\_\_\_\_

Other \_\_\_\_\_

Have you ever had any breast procedures?

**YES NO** Surgical Biopsy **Right Left** Date \_\_\_\_\_

**YES NO** Ultrasound Core Biopsy **Right Left** Date \_\_\_\_\_

**YES NO** Ultrasound Aspiration **Right Left** Date \_\_\_\_\_

**YES NO** Mammotome **Right Left** Date \_\_\_\_\_

**YES NO** Implants **Right Left** Date \_\_\_\_\_

**YES NO** Reduction **Right Left** Date \_\_\_\_\_

Have you ever been diagnosed with breast cancer? **NO YES**

If **YES** what treatment did you receive?

**YES NO** Mastectomy **Right Left** Date \_\_\_\_\_

**YES NO** Lumpectomy **Right Left** Date \_\_\_\_\_

**YES NO** Radiation Therapy **Right Left** Date \_\_\_\_\_

**YES NO** Chemotherapy **Right Left** Date \_\_\_\_\_

Family History of Breast Cancer? **YES NO** Who? \_\_\_\_\_ Age of Diagnosis \_\_\_\_\_

At what age was your first menstrual period? \_\_\_\_\_ Do you still menstruate? **YES NO**

If **YES**, what was the start date of your last menstrual period? \_\_\_\_\_

Total number of pregnancies \_\_\_\_\_ Number of Children \_\_\_\_\_ Age of first pregnancy \_\_\_\_\_

Is there any chance that you are pregnant at this time? **YES NO**

Have you been breast feeding in the last six months? **YES NO**

Are you currently taking hormones? **YES NO** List \_\_\_\_\_ How long? \_\_\_\_\_

Have you had a hysterectomy? **YES NO** Date \_\_\_\_\_

Any other medical history we should be aware of? \_\_\_\_\_

I hereby state that the information listed above is accurate to the best of my knowledge.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date