# ZWANGER-PESIRI RADIOLOGY

# PATIENT REGISTRATION FORM

## Breast MRI



Appointment Date:

| Last Name | First Name | MI | Date of Birth | Male | Female |
|---|---|---|---|---|---|
| Street Address | | | | Height | Weight |
| City | Zip Code | Preferred Email Address | | | |
| Social Security # | Home Phone | Work Phone | Cell Phone | | |
| Employer Name | | | | | |
| Insured's Name | Insured's Employer | Relationship to Patient | | | |
| Insurance | ID# | | | | |
| Secondary Insurance | Secondary ID# | Secondary Insured's DOB | | | |

| | Yes | No |
|---|---|---|
| ***Are you here as the result of a car accident?*** | ☐ | ☐ |
| ***Are you here as the result of a work related*** | ☐ | ☐ |

**Why did you choose Zwanger-Pesiri Radiology?**

A) Friend/Family Member Recommendation

B) Doctor Referral

C) Advertisement (Radio, Newspaper, Etc.)

D) Convenience (Hours, location, etc.)

**ZWANGER-PESIRI RADIOLOGY**

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## Breast MRI



Patient Name ______________________________ Date ______________

| | Yes | No |
|---|---|---|
| ***Does your insurance have a deductible?*** | ☐ | ☐ |
| ***Do you have an HSA or HRA plan?*** If yes, we need a copy of your debit card. | ☐ | ☐ |

***Authorization for Treatment:*** I hereby consent to treatment by the radiologist and other medical staff for all local anesthetics, radiologic tests and/or procedures as deemed necessary by myself and the Zwanger-Pesiri Radiology staff:

*I am aware that additional charges may be incurred if a diagnostic mammogram is deemed necessary. I understand that according to my particular insurance plan, this may or may not be covered.*

***Authorization for Release of Information and Assignment of Benefits:*** I hereby assign to Zwanger-Pesiri Radiology, LLP those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with testing performed and treatment rendered. I request that payment of authorized benefits be made directly to Zwanger-Pesiri Radiology on my behalf. I fully understand that I am financially responsible for **any** and **all** amounts not otherwise paid by my insurance carrier:

I certify that the information on this form given by me for payment under Title XVIII(Medicare) is correct and complete. I authorize holder of medical or related information about me to be released to the Health Care Financial Administration (HCFA) and/or other health care coverage entity, any information needed of this or any related healthcare claim in writing or verbally. I further understand and agree to pay for services or amounts due when denied as not covered by Medicare or any other health insurance plans

I hereby authorize release of my films, images, reports and medical records as needed for subsequent medical care. In event of positive findings I authorize release of my results to my referring and treating physicians for their records.

I acknowledge that I have been provided with a copy of the Zwanger-Pesiri Radiology's Notice of Privacy Practices.

In addition, I give the right for Zwanger-Pesiri Radiology, LLP to contact the following person(s) to discuss medical treatment and/or billing information:

| Persons(s) | Relationship | Phone# |
|---|---|---|
| | | |
| | | |
| | | |

This authorization will remain in effect unless changed by me, while I am a patient of Zwanger-Pesiri Radiology, LLP.

## Pregnancy Denial Statement

***Women age 12-55*** (except ultrasound)

I hereby attest that there is **NO** possibility that I am pregnant.

______________________________

***Patient signature***

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## Breast MRI



Patient Name ________________________________________ Date ______________

**Breast MRI Patients Only**

Date of your last menstrual period? ____________________

Are you currently on any hormone medications? Yes/No Date started ___________

Reason for Breast MRI: _______________________________________________

Yes/No History of Breast Cancer? If Yes, year diagnosed ____________________

| Personal Breast History | RIGHT | DATE | LEFT | DATE |
|---|---|---|---|---|
| __Pain or tenderness | ______ | ______ | ______ | ______ |
| __Lump | ______ | ______ | ______ | ______ |
| __Nipple discharge | ______ | ______ | ______ | ______ |
| color: | ______ | ______ | ______ | ______ |
| **Surgical History** | | | | |
| __Cyst Aspiration | ______ | ______ | ______ | ______ |
| __Needle Biopsy | ______ | ______ | ______ | ______ |
| __Surgical Biopsy | ______ | ______ | ______ | ______ |
| __Lumpectomy (cancer) | ______ | ______ | ______ | ______ |
| __Mastectomy | ______ | ______ | ______ | ______ |
| __Radiation Therapy | ______ | ______ | ______ | ______ |
| __Chemotherapy | ______ | ______ | ______ | ______ |
| __Breast Reduction | ______ | ______ | ______ | ______ |
| __Breast Implants | ______ | ______ | ______ | ______ |
| __Silicone | | | | |
| __Saline | | | | |

Date of last mammogram:_________________________________

Date of last breast sonogram:______________________________

Films Included: Yes/No

**Do you have a family history of breast cancer?**

__None

__Mother Age at diagnosis?_______ Pre or Post Menopausal ____

__Sister Age at diagnosis?_______ Pre or Post Menopausal ____

__Daughter Age at diagnosis?________ Pre or Post Menopausal ____

__Other: Please list: ______________________________ Pre or Post Menopausal

I understand that payment is due at the time of service and that I am financially responsible for **ANY** and **ALL** amounts not otherwise paid by my insurance carrier.

I UNDERSTAND THAT MY ACCOUNT WILL BE SUBJECT TO AN ADDITIONAL $15.00 PROCESSING FEE EACH MONTH IF PAYMENT IS NOT RECEIVED BY THE DUE DATE INDICATED ON MY BILLING STATEMENT.

**I further attest** that the information I have provided on these ***forms*** are true to the best of my knowledge

Please sign here

_______________________________________________________________

***Patient or Legal Guardian Signature*** ***Date***