TULLAHOMA IMAGING

Patient Registration Form

PATIENT INFORMATION

MR#: _____ ADMIT DATE: _____

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Exam: _____ Diagnosis: _____

Requesting Physician: _____

For Female Patients Only

1. Date of last menstrual period: _____ Post Menopausal? ☐ Yes ☐ No
2. Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No
3. Hysterectomy? ☐ Yes ☐ No
   If yes, was it a complete hysterectomy? (removal of ovaries and uterus) ☐ Yes ☐ No
   Date of surgery: _____
4. Are you taking oral contraceptives or receiving hormonal treatment? ☐ Yes ☐ No
5. Are you currently breastfeeding? ☐ Yes ☐ No

Medical Records Release

Please sign the medical release below.
This allows our facility to obtain your previous exams or prior medical history as it pertains to today's exam.

Submitted to: Name of facility _____

_____

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Type of records requested: _____

I hereby authorize and request you to release the complete medical records mentioned above, including copies of the reports in your possession to Tullahoma Imaging.

_____ _____

Patient or Authorized Person Date

ACKNOWLEDGEMENT/WAIVER OF LIABILITY

Please initial after each statement below:

I hereby authorize and request payment to Tullahoma Imaging for any Medical Benefits due under the terms of my insurance policy for services rendered. I further authorize the release of all necessary information including reports, images and outcomes as requested by my Insurance Carrier(s). _____

I have been informed by Tullahoma Imaging that my procedure may not be a covered service. I understand that charges for all services provided but not covered by my insurance will be my financial responsibility. _____

I authorize the release of all or any portion of my medical record to any health care practitioner or facility designated by me. _____

_____ _____

Patient or Parent (If Minor) Signature Date

TULLAHOMA IMAGING

Patient Registration Form

PATIENT INFORMATION

MR#: _____ ADMIT DATE: _____

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Exam: _____ Diagnosis: _____

Requesting Physician: _____

PATIENT'S EMPLOYER INFORMATION

Employer: _____

GUARANTOR INFORMATION

Relationship to Patient: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Plan: _____

Policy #: _____ Group #: _____

Name of Insured (if other than patient): _____

SSN of Insured (if other than patient): _____ DOB of Insured_____

Insured's Relationship to Patient : _____

SECONDARY INSURANCE INFORMATION

Plan: _____

Policy #: _____ Group #: _____

Name of Insured (if other than patient): _____

SSN of Insured (if other than patient): _____ DOB of Insured_____

Insured's Relationship to Patient : _____

ACKNOWLEDGEMENT/WAIVER OF LIABILITY

Please initial after each statement below:

I hereby authorize and request payment to Tullahoma Imaging for any Medical Benefits due under the terms of my insurance policy for services rendered. I further authorize the release of all necessary information including reports, images and outcomes as requested by my Insurance Carrier(s). _____

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_____ _____

Patient or Parent (If Minor) Signature Date

TULLAHOMA IMAGING

Patient Screening Form

Office Use Only

Creatinine_____mg/dl

eGFR_____ml/min/1.73m^2

Patient Information

Name: _____ Date: _____

Age: _____ Date of Birth_____ Weight: _____

☐ Male ☐ Female Body part to be examined: _____

Reason for exam and/or symptoms: _____

How long have you had symptoms? _____

Medical Information

1. Have you had a reaction to a contrast medium or dye used for imaging? ☐ Yes ☐ No

   If yes, have you been premedicated? ☐ Yes ☐ No

2. Have you had a prior imaging study MRI, CT, Ultrasound, X-ray, ect.)? ☐ Yes ☐ No

3. Have you had a prior cystoscopy on endoscopy? ☐ Yes ☐ No

4. List prior surgeries:

   Type of Surgery: _____ Date: _____

   Type of Surgery: _____ Date: _____

   Type of Surgery: _____ Date: _____

   Type of Surgery: _____ Date: _____

5. Do you have:
   ☐ diabetes ☐ vasculitis ☐ high blood pressure ☐ renal disease/disorder
   ☐ asthma ☐ multiple myeloma ☐ pheochromocytoma ☐ heart disease/disorder
   ☐ lupus ☐ respiratory disease ☐ sickle cell anemia/trait ☐ congestive heart failure (CHF)
   ☐ systemic lupus erythematosus (SLE) ☐ liver failure
   ☐ allergies _____ _____ _____
   _____ _____ _____

6. Do you take Actoplus Met (XR), Avandament, Diaben, Diabex, Diaformin, Fortamet, Glucophage (XR), Glucovance, Gluformin, Glumetza, Invokamet, Janumet (XR), Kombiglyze (XR), Metaglip, Metformin, Obimet, Prandimet, or Raiomet?
   ☐ Yes ☐ No

7. List current or recently taken medication and doses: _____ ☐ Unknown
   _____

8. Smoking status: ☐ Never ☐ Decline to state ☐ Current ☐ Former
   If current or former smoker: how many packs per day_____ for how many years_____

9. Do you have a personal history of cancer? ☐ Yes ☐ No
   If yes, describe type: _____
   Describe current or past treatments: (i.e. radiation or chemotherapy) _____
   Date of treatment: _____

10. Please list any additional information you feel pertinent to today's exam: _____

TULLAHOMA IMAGING
3D Clarity HD Mammography & Diagnostic CT

2114 NORTH JACKSON ST, SUITE B.
TULLAHOMA, TN 37388
P: 931.454.9849

PATIENT HISTORY AND RISK ASSESSMENT SHEET

DATE _____

NAME _____ DOB _____ AGE _____ PHONE# _____

HEIGHT: _____ WEIGHT: _____

DR'S OFFICE WHERE YOU WANT REPORT TO BE SENT? _____

WHERE AND WHEN WAS YOUR LAST MAMMOGRAM DONE? _____

APPROXIMATE AGE AT FIRST MENSTRUAL PERIOD? _____ LAST MENSTRUAL PERIOD? _____

ARE YOU PREGNANT? _____ HAVE YOU GIVEN BIRTH? _____ IF SO, WHAT AGE? _____

HAVE YOU PASSED MENOPAUSE? _____ IF SO, WHAT AGE? _____

HAVE YOU EVER TAKEN HORMONE REPLACEMENT THERAPY? _____ IF SO, ARE YOU TAKING IT NOW? _____

HOW LONG DID YOU TAKE IT? _____

HAVE YOU HAD ANY TYPE OF CANCER? _____ IF SO, WHAT KIND? _____

HAVE YOU HAD A NEEDLE BIOPSY OR LUMPECTOMY FOR BREAST BIOPSY? _____

LEFT, RIGHT OR BOTH? _____ WAS IT CANCER OR BENIGN (NORMAL)? _____

LUMPECTOMY FOR CANCER? _____ RADIATION THERAPY? _____ MASTECTOMY? _____

BREAST REDUCTION? _____ DO YOU HAVE IMPLANTS? _____ IF SO, SALINE OR SILICONE? _____

REASON FOR TODAYS EXAM - CIRCLE ALL THAT APPLY

ROUTINE SCREENING(NORMAL) • BREAST LUMP (RIGHT OR LEFT) • SKIN CHANGES • NIPPLE DISCHARGE • SORENESS

PAIN (IN ONE AREA OR ALL OVER-LEFT OR RIGHT) • FOLLOW-UP FROM PREVIOUS EXAM

IF YOU HAVE PROBLEMS, HOW LONG HAVE YOU HAD THEM? _____ WHICH BREAST? _____

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? _____

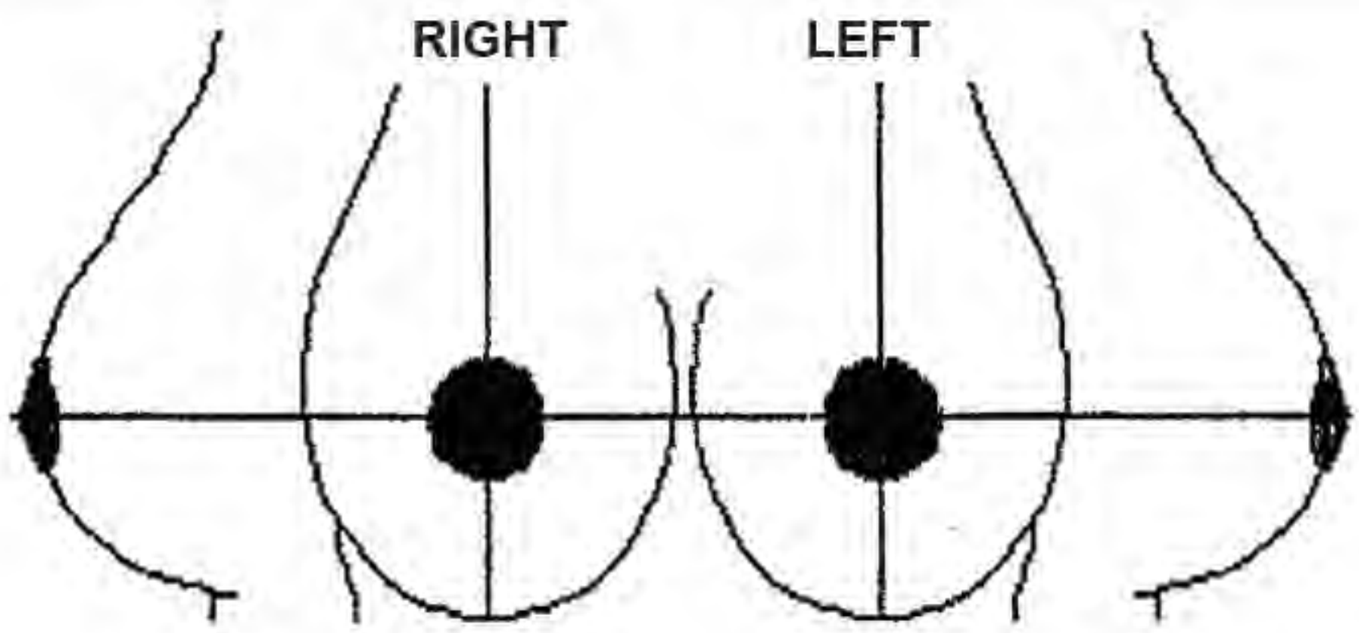
IF SO, WHAT RELATIONSHIP TO YOU? _____ AGE AT DIAGNOSIS? _____

OVARIAN CANCER? _____

IF SO WHAT RELATIONSHIP TO YOU?" _____ AGE AT DIAGNOSIS? _____

FOR TECHNOLOGIST USE

LIFETIME RISK



TECHNOLOGIST _____

TULLAHOMA IMAGING
3D Clarity HD Mammography & Diagnostic CT

MEDICAL RECORD RELEASE FORM

Patient's Name:_____

Date of Birth:_____

PREVIOUS FILMS/IMAGES AND CORRESPONDING REPORTS

Date(s):_____

Location:_____

PLEASE SEND ALL RECORDS TO:
Tullahoma Imaging
ATTN: Michelle Perry
2114 N. Jackson St. Suite B.
Tullahoma, TN. 37388

I am requesting a copy of my **previous mammogram(s) and/or breast ultrasound images, and/or all breast imaging studies** from the above entity for the purpose of comparison to current mammographic studies. As the person signing this consent, I understand that I am giving permission to the above-named provider for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included in my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless recipient is a provider who makes disclosures permitted by law.

_____ _____

Patient's Signature Date