DIAGNOSTIC IMAGING CENTERS, P.A.

Breast Imaging Exam Form

Tech Initials: _____

MRN #: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: Date of last mammogram: _____

Reason for today's exam: ☐ First mammogram ever ☐ Annual mammogram

New symptoms may require Doctor's order ☐ New symptom/problem ☐ 6-month follow-up

*Describe your *new* breast problem and how long you have had it (if applicable): _____

_____

MEDICAL INFORMATION AND RISK ASSESSMENT

FAMILY HISTORY

1. Has anyone in your Family been diagnosed with breast cancer? ☐ Yes ☐ No

✓ If *Yes* , please check the relative and age at time of diagnosis:
☐ Mother/Age____ ☐ Daughter/age____ ☐ Sister/age____
☐ Aunt/Age____ → ☐ Maternal ☐ Paternal
☐ Grandmother/Age____ → ☐ Maternal ☐ Paternal

PERSONAL HISTORY

1. Race: ☐ White ☐ African American ☐ Hispanic ☐ Unknown ☐ Asian-American ☐ American Indian/Alaskan Native

2. Ethnicity (If applicable): ☐ Chinese ☐ Japanese ☐ Filipino ☐ Hawaiian ☐ Other Pacific Islander ☐ Other Asian-American

3. Have *you* previously been diagnosed with breast cancer? ☐ Yes ☐ No

4. Do *you* have a history of female cancer? *(Ovarian, uterine, cervical)* ☐ Yes ☐ No

5. Known BRCA1 or BRCA2 mutation or similar genetic syndrome? ☐ Yes ☐ No

6. Do you take hormones? ☐ Yes ☐ No

✓ If *Yes* , please check the ones you are currently using:
☐ Birth control ☐ Estrogen ☐ Progesterone
Length of time on hormones: _____ ☐ Months ☐ Years ☐ Tamoxifen ☐ Evista ☐ Arimidex

7. Age at *first* menstrual period? ☐ Age 7-11 ☐ Age 12-13 ☐ Age 14 or older

8. Date of your *last* menstrual period: _____

9. Are you post menopausal? ☐ Yes ☐ No

10. Are you pregnant? ☐ Yes ☐ No

11. Age when you had your first child? ☐ No Births ☐ Under 20 ☐ Age 20-24 ☐ Age 25-29 ☐ Age 30 + ☐ Unknown

BREAST PROCEDURES

1. History of breast biopsy? ☐ Yes ☐ No ☐ Rt ☐ Lt Date(s): _____

✓ If *Yes* , how many times? ☐ 1 ☐ More than 1

Did any of the biopsies show *atypical* hyperplasia? *(or other high risk marker on biopsy²)* ☐ Yes ☐ No

2. History of mastectomy? ☐ Yes ☐ No ☐ Rt ☐ Lt ☐ Bilateral Date: _____

3. History of lumpectomy? ☐ Yes ☐ No ☐ Rt ☐ Lt ☐ Bilateral Date: _____

4. Treatment: ☐ Chemotherapy ☐ *with* radiation ☐ *without* radiation

5. History of breast reduction surgery? ☐ Yes ☐ No Date: _____

6. History of breast implant surgery? ☐ Yes ☐ No Date: _____

Patient Signature: _____ Date: _____

DIAGNOSTIC IMAGING CENTERS, P.A.

MOBILE MAMMOGRAPHY

Medical Records Release

Patient Name: _____

MRN: _____ DOB: _____

Exam: _____

Referring Provider: _____

DIC Location: _____ Date: _____

_____

_____

Patient's Prior Last Name (If Applicable): _____ ❑ **N/A**

Please provide the following information so that we may obtain your latest mammogram and/or other breast imaging records for comparison.

Name of Facility: _____

Address of Facility: _____

City/State/Zip: _____

Phone/Fax: _____

I hereby authorize and request you to release all breast imaging, including copies of reports in your possession to Diagnostic Imaging Centers, P.A.

_____ X_____ _____

Please print name | Patient or authorized signature | Date

REPORTS: Please fax reports to our Mobile Mammography Department at (913) 955-3744. If you need to speak to one of our Mobile Mammography Team Members, you can reach them at (913) 222-9758 or (913) 602-6692.

IMAGES: If you are unable to cloud images, please mail CD to our Medical Records department.

Diagnostic Imaging Centers, P.A.
6650 W. 110th St. Suite 100
Overland Park, KS 66211

Thank you!

DIAGNOSTIC IMAGING CENTERS, P.A.

Patient Registration Form

Patient Name: _____

MRN: _____ DOB: _____ DIC Location: _____ Date: _____

Exam: _____ _____

Referring Provider: _____ _____

PATIENT INFORMATION

Age: _____ ❑ Male ❑ Female SSN #: _____

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

Home Phone: _____ Daytime Phone: _____ Email Address: _____

_____ ***By placing my initials in the space provided, I verify that I have reviewed the information above and it is correct.***

GUARANTOR INFORMATION

Relationship to Patient: _____ Name: _____

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

PRIMARY INSURANCE INFORMATION

Plan: _____ Policy #: _____

Group #: _____ Insured's Relationship to Patient: _____

Name of Insured: _____ SSN of Insured: _____ DOB of Insured: _____
(If other than Patient)

SECONDARY INSURANCE INFORMATION

Plan: _____ Policy #: _____

Group #: _____ Insured's Relationship to Patient: _____

Name of Insured: _____ SSN of Insured: _____ DOB of Insured: _____
(If other than Patient)

ACKNOWLEDGEMENT / WAIVER OF LIABILITY

Please initial by each statement below:

1. _____ I hereby authorize and request payment to Diagnostic Imaging Centers, P.A. 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).

2. _____ I have been informed by Diagnostic Imaging Centers, P.A. 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.

3. _____ 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***

DIAGNOSTIC IMAGING
CENTERS, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Diagnostic Imaging Centers Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

DIAGNOSTIC IMAGING CENTERS, P.A.

Vaccines of all types can result in temporary swelling of the lymph nodes, including under your arm. This swelling is usually a sign that the body is making antibodies and is a normal response. We ask for the following information in case we see a change on your mammogram.

Patient Name: _____

Patient date of birth: _____

Vaccine in the last 90 days: ☐Yes ☐No Date of vaccine: _____

☐Right Arm ☐Left Arm Type of vaccine: _____

www.dic-KC.com

913-344-9989 ◆ 816-444-9989

❑ INDEPENDENCE
4911 S Arrowhead Dr #100
Independence, MO 64055

❑ LEE'S SUMMIT
301 NE Mulberry St #100
Lee's Summit, MO 64086

❑ PLAZA
4801 Main St #200
Kansas City, MO 64112

❑ KC NORTH
303 NE Englewood Rd
Kansas City, MO 64118

❑ LIBERTY
9151 NE 81st Ter #250
Kansas City, MO 64158

❑ ST. JOSEPH
3937 Sherman Ave
St. Joseph, MO 64506

❑ OLATHE
13795 S Mur-Len Rd #100
Olathe, KS 66062

❑ OVERLAND PARK
6650 W 110th St #100
Overland Park, KS 66211

❑ WYANDOTTE COUNTY
9201 Parallel Pkwy
Kansas City, KS 66112

❑ MOBILE 3D MAMMOGRAPHY

DIAGNOSTIC IMAGING CENTERS, P.A.

Coronavirus (2019-nCov) Patient Screening Form

Date: _____

Patient Name: _____ DOB: _____

Please answer "Yes" or "No" to all questions below. Provide additional details if applicable.

Does the patient have a positive COVID-19 test? ○ Yes ○ No

Date of test result: _____

Has the patient had close contact with a person with confirmed COVID-19 in the last 14 days?

○ Yes ○ No

Does the patient have the following signs and symptoms?

- Fever _____°F/Chills ○ Yes ○ No
- Recent onset Cough/Difficulty Breathing ○ Yes ○ No
- Recent abdominal pain/diarrhea ○ Yes ○ No
- New loss of taste or smell ○ Yes ○ No
- Other flu-like symptoms ○ Yes ○ No

Patient/Guardian Signature: _____

Screener Initials_____