M·U·S·I·C
Mammography & UltraSound
Imaging Center, PLLC

John M. Elliott, M.D.

Judy M. Yancey, M.D.

PATIENT INFORMATION FORM			
MRN:		Appt Date:	Appt Time:
Last Name:		Social Security #:	
First Name:	Mid. Initial:	Date of Birth:	
Home Address:		Age:	Sex:
Home Address 2:		Home Phone #:	
City, State, Zip:		Work Phone #:	
PT Email:		Cell Phone #:	
Race: ☐Caucasian ☐African American ☐Asian ☐Native American		Ethnicity: ☐Hispanic/Latino ☐Other ☐Not Rptd/Returned	
Referring Provider:		Referring Phone #:	
Primary Care Physician:			
EMGERGENCY CONTACT INFORMATION: In case of emergency who should be notified?			
Name: «ContactName»		Tel #: «ContactPhone»	
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING PERSON(S):			
Name:		Relationship:	
Name:		Relationship:	
Name:		Relationship:	
PRIMARY INSURANCE			
Plan Name:		Group #:	
Plan Tel #:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #:	
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other			
SECONDARY INSURANCE			
Plan Name:		Group #:	
Plan Tel #:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #:	
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other			

Assignment of Insurance Benefits

I authorize payment of medical benefits to: Mammography and Ultrasound Imaging Center for services rendered. I also authorize the release of any medical information necessary to process my insurance claims. I request and authorize that payment/insurance benefits be made directly to Mammography and Ultrasound Imaging Center any services furnished to the above named patient by Mammography and Ultrasound Imaging Center. The signature below shall suffice for all insurance forms on a continuing basis. I agree to pay Mammography and Ultrasound Imaging Center for all charges for services not covered by Insurance Payer.

Patient or authorized persons signature: _____ Date: _____

7550 W University Avenue, Suite A | Gainesville, FL 32607 | Tel: (352) 727-4911 Fax: (352) 505-5211
www.mammographyandultrasoundimagingcenter.com

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BMD QUESTIONNAIRE

MRN: NAME: DATE:

DOB: SEX: ❒FEMALE ❒MALE ETHNICITY: ❒WHITE ❒BLACK ❒HISPANIC

REFERRING: _____

HEIGHT: _____ WEIGHT: _____ MENOPAUSE AGE: _____

Dominant Hand: (please circle one) Right Left

Have you had a previous hip or vertebral fracture? ❒ Y ❒ N

Have you had any fractures during your adult life which did not result from significant trauma? ❒ Y ❒ N

Did either of your parents ever have a hip fracture? ❒ Y ❒ N

Do you smoke? ❒ Y ❒ N

Have you ever taken Glucocorticoids? ❒ Y ❒ N

Do you have rheumatoid arthritis? ❒ Y ❒ N

Do you have secondary osteoporosis? (a condition/disease that can cause osteoporosis)? ❒ Y ❒ N

Do you drink 3 or more alcoholic drinks per day? ❒ Y ❒ N

Are you being treated for osteoporosis? ❒ Y ❒ N

Are you currently taking any of the following medications?

❒ Actonel ❒ Boniva ❒ Evista

❒ Forteo ❒ Fosamax ❒ Prolia

❒ Miacalcin ❒ Protelos ❒ Reclast

❒ Calcium ❒ Vitamin D ❒ Hormone Replacement Therapy

❒ Other-Please Specify:

Do you have any of the following medical conditions?

❒ Anorexia or Bulimia ❒ Asthma or emphysema ❒ End stage renal disease

❒ Seizure disorders ❒ Cancer ❒ Inflammatory bowel diseases

❒ Hysterectomy ❒ Hyperparathyroidism

❒ Other-Please Specify:

What was your maximum height? _____

Do you perform weight bearing exercise regularly? ❒ Y ❒ N

Do you consume dairy products? ❒ Y ❒ N

Do you drink caffeinated beverages? ❒ Y ❒ N

If female:

At what age did your period start? ❒ Y ❒ N

Are you premenopausal? ❒ Y ❒ N

How many full term pregnancies have you had? ❒ Y ❒ N

Have you ever missed a period for more than 6 months in a row (not including pregnancy or menopause)? ❒ Y ❒ N

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Release of Records Authorization

Consent to use, obtain, and disclose protected health information

MRN: Appt Date: Appt Time:

Patient Name: DOB: SSN:

I, «PatientFullName», hereby give my permission to Mammography and Ultrasound Imaging Center to obtain my protected health information from others for the purpose of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I hereby give my permission to Mammography and Ultrasound Imaging Center to use and disclose my protected health information disclosed by another covered entity for the purposes of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

This release covers all my personal health information including but not limited to medical reports, progress notes, CDs, films, diagnostic studies, lab work, and any other documentation requested by Mammography and Ultrasound Imaging Center for the purposes of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I understand that Mammography and Ultrasound Imaging Center may request this information from health care providers, hospitals, ancillary service providers, and other entities. I understand that Mammography and Ultrasound Imaging Center will use my personal health information solely for the purposes of treatment, obtaining payment, and supporting the day-today operations of the practice

A copy of this release is as valid as the original. This is a lifetime release unless revoked by me in writing.

Facility Name: _____

Facility City/State: _____

Type of records: _____

Name of Person Signing Below: _____

Relationship to Patient: _____

Signature of Patient or Parent/Guardian: _____

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CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS, AND CONSENT TO PERFORM SERVICES ORDERED

I, «PatientFullName» understand that as part of my health care, ***Mammography & Ultrasound Imaging Center*** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that ***Mammography & Ultrasound Imaging Center*** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ***Mammography & Ultrasound Imaging Center*** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should ***Mammography & Ultrasound Imaging Center*** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I UNDERSTAND THAT BY SIGNING THIS FORM I AM CONSENTING TO THE SERVICES ORDERED

I fully understand and accept / decline the terms of this consent.

(Circle one)

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY **MRN:**

[ ] Consent received by_____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on_____

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Today's Date: _____ MRN: _____

Patient Name: _____ Sex: M F

❒ NO CHANGES FROM PRIOR VISIT ❒ DECLINE TO ANSWER

RACE

❒ Caucasian/White ❒ Black/African American ❒Asian ❒ Native America ❒ Asian Pacific American

❒ Pacific Islander ❒ Subcontinent Asian American ❒ American Indian/Native Alaskan

❒ Native Hawaiian ❒ Other Race ❒ Decline to Answer ❒ Do not know

ETHNICITY

❒ Latino/Hispanic ❒ Non-Latino Hispanic ❒ Decline to answer

PREFERRED LANGUAGE

❒ English ❒ Other: (Please Specify) _____

TOBACCO HISTORY

Do you currently Smoke? ❒ YES ❒ NO If No, Have you ever Smoked? ❒ YES ❒ NO

If YES, do you smoke daily? ❒ YES ❒ NO

Do you currently use smokeless tobacco? ❒ YES ❒ NO Have you ever used smokeless tobacco? ❒ YES ❒ NO

MEDICATION HISTORY

ALLERGIES

❒ No Known Allergies	

CURRENT MEDICATION LIST

❒ NOT CURRENTLY ON ANY MEDICATIONS

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____