Drs.Maklansky, Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky, Mester, and Mecca
NYMI Associates PC 165 East 84th st. New York NY 10028 Tel. (212) 535-9770 Fax (212) 988-1520

PATIENT INFORMATION   Account

Name ____
Last   First   Initial

Address ____
Street   City   State   Zip

SS# _______________ Sex M☐ F☐ Birth Date _________ Age _____ Marital Status Choose ______

Home Phone (___)___________Cell Phone (___)______________ Work Phone (__)____________

Referring Physician ___________________________________ Phone # __________________________

Referring Physician #2 _______________________ PATIENT EMAIL ADDRESS:

ELECTRONIC MEDICAL RECORD INFORMATION

- What is your race/ethnicity___________________ Native language spoken _________________
- Smoking Status (please circle one): Never ☐ Sometimes ☐ Every Day ☐ Former ☐
- List of Current Medications____
  ____
- Please provide list of Medication Allergies ______________________________
  ____
- Please provide a list of current conditions ______________________________
  ____

INSURANCE INFORMATION

Primary Insurance Carrier___________________________________ Phone (___)________________

Policy Number ____________________________ Group Number ___________________________
Policy Holder ______________________ Date of Birth _________ Relationship _______________

Secondary Insurance Carrier___________________________________ Phone (___)________________

Policy Number ____________________________ Group Number ___________________________
Policy Holder ______________________ Date of Birth _________ Relationship _______________

I authorize payment directly to NYMI Associates on my behalf for services rendered by them. I also authorize them to release any information needed to determine these benefits. I understand that I am responsible for payment of their services if full payment is not made by the insurance carrier.

Date_______________ Signature____

BREAST IMAGING QUESTIONNAIRE

PATIENT NAME:____________________________________ **DOB:** __________
AGE:____________________

Phone number(s): Home:______________ Work:______________Cell:______________________________

1. Have you had a mammogram performed within the last 5 years? ☐**Yes** ☐ **No**
   ☐**Here**

☐**Elsewhere?**____

2. **Have you ever had breast surgery?** ☐**Yes** ☐ **No** If so,
   ▫**BIOPSY** ▫**ASPIRATION** ▫**MASTECTOMY** ▫**LUMPECTOMY** ▫**RADIOTHERAPY** ▫**IMPLANTS** ▫**REDUCTION**
   Which Breast(s)?: ☐**Right** ☐ **Left** ☐ **Both** When?:_____________________
   Results: ☐Benign: ________________ ☐ Malignant: _____________________

3. **Current breast problems?** ☐**Yes** ☐ **No**

▫**Lump**________ ▫**Right** ▫ **Left** ▫ **Both**
▫**Discharge** _____ ▫**Right** ▫ **Left** ▫ **Both**
▫**Pain/Tenderness**____ ▫**Right** ▫ **Left** ▫ **Both**
▫Other: _____________________________

4. **Family History of Breast Cancer** ☐ None If yes, please indicate age diagnosed

Mother________ **Father** ________ **Daughter**________ **Sister**________
Aunt (maternal/paternal) ________ **Grandmother** (maternal/paternal) ________
First cousin (maternal/paternal) ________

5. **Physical breast exam by your physician within last 12 months?** ☐**Yes** ☐ **No**

6. **Name of your referring physician (s):**

#1 ____
#2____________________________________ #3 _____________________________________

TECHNOLOGIST'S NOTES:

Pregnancy Waiver

I, the undersigned fully understand the x-ray procedure. I understand that if I am pregnant at this time radiation may be harmful to the fetus.

Patient Signature:____________________________________**Date:**_____________________