(602) 485-7482

Dear Pinnacle Radiology Patient,

This is your registration form for your appointment at ***Pinnacle Radiology-DEER VALLEY*** **19636 North 27th Ave, LL1 (Basement) Phoenix, AZ 85027**. Please follow the appropriate preparation for your examination.

This patient registration form and appropriate history forms can be printed, completed and given to us at your appointment. Bringing completed forms will reduce waiting time at your appointment.

If you have visited a Pinnacle Radiology facility in the past 6 months and your information or insurance has not changed, it is not necessary to complete the patient registration form. Please bring your insurance card and any applicable co-pays with you at the time of your appointment. Also, remember to bring your doctors orders if they provided the order to you.

If you have prior studies of the same anatomic area that your appointment is scheduled for, it is very important to arrange for those studies to be available to us for comparison. This includes any CT's, X-rays, or MRI's, even if the test you are currently scheduled for is of a different modality. The best method is to hand carry them if possible, but you can call the facility where the films were done and ask for them to be mailed to the address listed above. Only you can request the release of films due to federal regulations. If you are unsure of the facility, your healthcare provider at that time should be able to tell you where you had prior examinations performed.

If you are unable to keep this appointment, 24 hour notice would be greatly appreciated.

Please call **(602) 485-7482** if you need further instructions.

Sincerely,

The Staff of Pinnacle Radiology

Pinnacle Radiology

Patient Registration Form

PLEASE PRINT CLEARLY

Patient Information

Last Name____Soc. Sec # ______-____-____
First Name_____________________________M. Initial_____ Gender M F Marital Status___
Address____Birthdate____-___-____Age____
City________________________State_________Zip_______Home Phone____-____-_______
Work Phone____-_____-______

EMERGENCY CONTACT

Name____Relationship to patient__________
Telephone #_______________________________________

Responsible Party (Guarantor if not patient)

Soc Sec #_____-______-_______ Relationship to patient_________
Last Name____DOB_______________________
First Name____Home Phone____-____-_______
Address____
City________________________State__________Zip_______Work Phone_____-____-____
Employer____
Address____
City________________________State_____________________Zip________

Insurance Information

Primary Insurance_____________________________________Insured ID#______________
Address____Group___________________
City______________________State_____________Zip_______Telephone # ___-___-_____
Policy Owner____Birth Date_____-_____-____
Patient Relation to Policy Owner_________________________Eff date___________Exp____
Second Insurance_____________________________________Insured ID#______________
Address____Group___________________
City______________________State_____________Zip_______Telephone # ___-___-_____
Policy Owner____Birth Date_____-_____-____
Patient Relation to Policy Owner_________________________Eff date___________Exp____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS.
I hereby authorize Pinnacle Radiology to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning my testing. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to myself or my dependents. I understand I am financially responsible for amounts not covered by my health insurance.

Signature____Date______________________

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Screening or Diagnostic Mammography Preparation

Do not use any Powders, lotions or deodorants on the day of the examination.

IT IS CRITICAL THEY YOU BRING ANY PRIOR MAMMOGRAMS OR BREAST ULTRASOUNDS WITH YOU TO YOUR APPOINTMENT, OR ARRANGE FOR THEM TO BE SENT TO PINNACLE RADIOLOGY-DEER VALLEY.

MAMMO WORKSHEET

Breast History

Last Name:_______________ First Name:_______________ M.I.:_______

Street Address:_______________ City / State / Zip Code:_______________

Home Phone:_______________ Work Phone:_______________ Other:_______________

Date of Birth:_______________ Age at Present:__________ Previous Mammogram?: **Yes** **No**

Reason for today's exam:_______________

Location of Previous Mammogram:_______________ Dates:_______________

Referring Doctor's Name:_______________

Risk Factors for breast cancer: Please check all that apply.

- ☐ No family history of breast cancer
- ☐ Risk factor unknown
- ☐ History of gynecological cancer
- ☐ Pre-menopausal mother or multiple pre-menopausal first degree relatives had breast cancer
- ☐ Aunt, grandmother or cousin had breast cancer (weak)
- ☐ Mother, sister, post-menopausal had breast cancer (intermediate)
- ☐ Personal history of cancer What area?:_______________

Patient's History: **Date of last menstrual cycle:**_______________ **Height:**__________ **Weight:**__________

First menstruation: age__________ First full pregnancy: age__________ Number of children birthed?__________

Hysterectomy: age__________ Menopause: age__________ Number of children breast fed?__________

Ovaries removed: What year?_______________ ☐ Left ovary ☐ Right ovary ☐ Both ovaries

Please insert the year on the following:

	First Use	Last Use	How long?
Hormonal contraceptives:	First Use - ______	Last Use - ______	How long? - ______
Estrogen:	First Use - ______	Last Use - ______	How long? - ______
Progesterone:	First Use - ______	Last Use - ______	How long? - ______
Tamoxifen:	First Use - ______	Last Use - ______	How long? - ______

Breast Procedures: Please insert at what age and check all that apply.

Procedure	Age			
Biopsy:	age_____	☐ Left	☐ Right	☐ Both
Cyst Aspiration:	age_____	☐ Left	☐ Right	☐ Both
Lumpectomy:	age_____	☐ Left	☐ Right	☐ Both
Reduction:	age_____	☐ Left	☐ Right	☐ Both
Radiation Therapy:	age_____	☐ Left	☐ Right	☐ Both
Mastectomy:	age_____	☐ Left	☐ Right	☐ Both

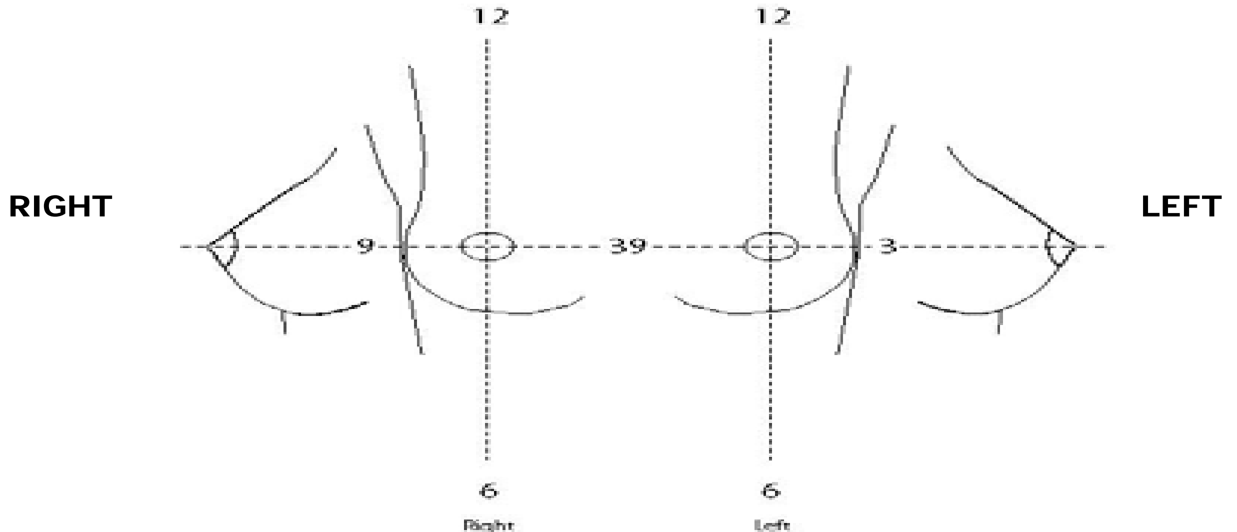
Implants: age_____ ☐ Left ☐ Right ☐ Both

Type: ☐ Silicone ☐ Saline ☐ Combination

Chemotherapy: Age:_______________

Patient Signature:_______________ **Date:**_______________

Tech Notes:



Tech Signature:_______________ **Date:**_______________