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_____

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165 East 84th Street • New York,NY • 10028
www.NYMIassociates.com

BREAST IMAGING QUESTIONAIRE

PATIENT NAME:_____
Last **First** **M.I.**

Date of Birth:_____Age:_____

Phone number(s):Home:_____Work:_____Cell:_____

1. Date of last menstrual period?_____
2. Have you ever had a mammogram? ☐**Yes** ☐ **No** If so,when:_____
   where:_____
3. Have you ever had breast surgery? ☐**Yes** ☐ **No** if so,
   □BIOPSY □ASPIRATION □MASTECTOMY □LUMPECTOMY □RADIOTHERAPY □IMPLANTS
   Which Breast(s)? ☐**Right** ☐ **Left** ☐ **Both** When?:_____
   Results: ☐**Benign** :_____ ☐ **Malignant**:_____
4. Do you have a family history of **BREAST** cancer? ☐**Yes** ☐ **No**
   If so, (check all that apply):☐**Mother** ☐ **Father** ☐ **Sister** ☐**Grandmother** ☐ **Aunt** ☐ **Other**
   If so, what age?:_____
5. Are you experiencing any problems with your breasts now?☐**Yes**☐ **No** if so, please indicate:
   □Lump----------□Right □ Left □ Both
   □Discharge ----------□Right □ Left □ Both
   □Pain/Tenderness------□Right □ Left □ Both

□Other:_____

6. When was the last time your breasts were physically examined by your physician?:_____
7. Are you being treated for any other illnesses? If so, Please describe_____
8. Name of your referring physician:_____
9. How did you hear about our practice?* Annual Exam(s), *Referring Physician,* Friend,* Street Fair

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:_____

I request the payment of authorized insurance benefits be made on my behalf to the aforementioned physicians for any services furnished by the physician. I authorized any holder of medical information about me to release to the insurance carrier and it's agents any information needed to determine these benefits or the benefits payable for related services. This authorization will be valid for all subsequent visits unless cancelled by the beneficiary.

Patient Signature:_____Date:_____