BERGEN IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

EXISTING PATIENT BREAST IMAGING REGISTRATION FORM

TECHNICIAN INITIALS

M: □ TB □ KS □ SS □ MS □ LM

US: □ JD □ DD □ RC

Account #: _____ Today's Date: _____

Name: Last _____ First: _____

Date of Birth: _____ Age: _____

Send the report to the following physician(s):

_____

_____

_____

Are you pregnant? □ Yes □ No First day of your last menstrual period: _____

Have you breastfed in the last three months? □ Yes □ No

Are you currently on Hormone Replacement Therapy? □ Yes □ No

Do you have any new significant medical conditions? □ No

□ Yes – please explain: _____

What is the reason for your visit?

□ This is a routine exam. **I DO NOT CURRENTLY HAVE ANY BREAST PROBLEMS.**

□ I have the following problem: _____

Since your last visit, have you had a breast biopsy or any surgical procedures? □ No

□ Yes – please explain: _____

Since your last visit, has anyone in your family received a breast cancer diagnosis? □ No

□ Yes – please identify their relationship to you and age: _____

Since your last visit, have you or anyone in your family been tested for BRCA or any other breast cancer genetic mutations? □ No □ Yes – please identify yourself or relationship to you and results of the test:

_____

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patient's signature: _____ Date: _____

NOTE: If you have previous discs and/or reports with you, please give them to the receptionist upon check-in.