CYPRESS WOMEN'S IMAGING

Date_____ Referring Physician_____

PATIENT		SUBSCRIBER'S NAME	
FIRST NAME (Please Print) Middle Initial		FIRST NAME (Please Print) Middle Initial	
LAST NAME		LAST NAME	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE ZIP CODE		CITY, STATE ZIP CODE	
HOME PHONE	WORK PHONE	HOME PHONE	WORK PHONE
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER	
EMPLOYER	OCCUPATION	EMPLOYER	OCCUPATION
SEX	MARITAL STATUS	SEX	MARITAL STATUS
BIRTHDATE	AGE	BIRTHDATE	AGE
RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____			
NAME, ADDRESS AND PHONE OF PERSON NOT LIVING WITH YOU, TO CONTACT IN CASE OF EMERGENCY			

INSURANCE INFORMATION	
PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
ADDRESS	ADDRESS
INSURANCE I.D.#	INSURANCE I.D.#
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME

IS INJURY A RESULT OF CAR ACCIDENT? _____
(If yes, give name & address of auto carrier in above spaces)

IS X-RAY FOR WORKMANS COMPENSATION?_____

IF YES, GIVE DATE OF INJURY _____

GIVE A BRIEF HISTORY OF YOUR ILLNESS:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby assign and authorize for direct payment for radiological and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance.

Signed Date

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Wichita Radiological Group to release any information acquired in the course of my examination or treatment to my referring doctor and/or insurance company.

Signed Date

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

Cypress Women's Imaging

DENSITOMETRY HISTORY SHEET

Date_____ DR._____ Cypress East or Hillside

LABEL

Height_____ Weight_____

Your Race_____

(Circle or Fill in correct answer)

Have you been diagnosed with osteoporosis or osteopenia? Yes or No

Have you ever been tested for osteoporosis? Yes or No If yes, what type of test? (Dexa, Heel, Cat Scan, X-ray) When?_____ Where?_____

Has a parent or sibling ever had osteoporosis? Yes or No Who?_____
Do you ever have back pain? Yes or No
Mild or Severe Dull or Sharp Intermittent or Constant

Are you: Still having periods, Peri-Menopausal or Post-Menopausal?
Last period?_____ Have you ever had a hysterectomy? Yes or No Year?_____

Have you had your ovaries removed? Yes or No

Are you taking hormones? Yes or No How Long?_____

Are you, or have you taken cortisone, prednisone or other steroids for lung conditions or other reasons? Yes or No How Long?_____

Are you taking any medications or supplements for bone health? Yes or No
What type?_____ Dosage?_____ How Long?_____

Do you have hyperparathyroidism or high calcium levels in your blood? Yes or No

Exercise regularly? Yes or No

Have you ever had any fractures as an adult? Yes or No
Please Describe:_____

Do you have a history of cancer? Yes or No What type?_____

Do you have a history of back or hip surgery? Yes or No
Please describe:_____

Do you have a history of a chronic bone disease? Yes or No

Have you had any barium studies within the last two weeks? Yes or No