Patient Intake Form

Name: _____

DOB: _____ Age: _____

Address: _____

City: _____ Zip: _____

Occupation: _____

Email:
_____

Phone: (H) _____

(C) _____

(W) _____

For Office Use Only

Patient ID# _____ Report Ref# _____

Scan Type: _____ Scan Location: _____
Referred by: _____

Date of R&S submitted to EMI: _____

Date of R&S processed & sent to Patient: _____

Date Patient called regarding R&S findings: _____

Patient Receipt Sent: _____ Patient Report/Images Sent: _____

Doctor/Health Care Provider Patient Report/Images Sent: _____

Payment: _____ Cash _____ Check#:_____ CC: V MC D AE

Processing: Email, CD or Printed Followed Protocol: Yes No
Next Appt: _____ Notes: _____

Reason for today's visit: _____

Current Symptoms (SX): _____
_____

Current Treatment (TX): _____
_____

Previous Illnesses: _____
_____

Previous Surgeries/Dates: _____
_____

Previous Injuries/Dates: _____
_____

Current Medication(s): _____
_____

Thermography (HX): _____

Doctor or Health Care Provider's Email: _____

Contact person in case of emergency:

Name: _____ Phone: _____ Relationship: _____

Signature: _____ Date: _____

Breast Questionnaire

1. Do you have any close relative who has had breast cancer?	Yes	No
2. Have you ever been diagnosed with breast cancer?	Yes	No
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	Yes	No
4. Have you had any biopsies or surgeries to your breasts?	Yes	No
5. Have you had any breast cosmetic surgery or implants?	Yes	No
6. Have you had a mammogram in the past 12 months?	Yes	No
7. Have you had a mammogram in the past 5 years?	Yes	No
8. Have you had abnormal results from any breast testing?	Yes	No
9. Have you ever taken a contraceptive pill for more than 1 year?	Yes	No
10. Have you suffered with cancer of the womb?	Yes	No
11. Have you had pharmaceutical hormone replacement therapy?	Yes	No
12. Do you have an annual physical examination by the doctor?	Yes	No
13. Do you perform a monthly breast self exam?	Yes	No

14. How many mammograms have you had in total? _____

15. What was your age when you had your first mammogram? _____

16. How many births have you had? _____ Your age at birth of first child: _____

17. Did your periods start before the age of 12? _____ Or finish after the age of 50? ____

18. Do you smoke? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__

Have you recently had any of these breast symptoms:	**Right Breast**	**Left Breast**
Pain	θ	θ
Tenderness	θ	θ
Lumps	θ	θ
Change in breast size	θ	θ
Areas of skin thickening or dimpling	θ	θ
Secretions of the nipple	θ	θ

Notes: _____

_____

Patient Disclosure

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis, and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self -diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the Thermographic findings discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature: _____ Date: _____

Extended Breast Questionnaire

Patient Name: _____ Date:_____

Diagnosed with breast cancer:

Cancer type: Metastatic _____ Local _____ Lymph node involvement _____

When diagnosed: Month _____ Year _____

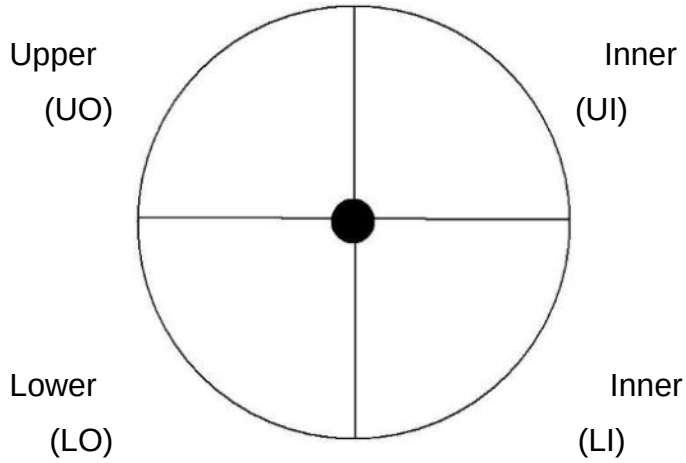
Where: Left Breast _____ Right Breast _____

Treatment: Surgery ____ Chemo ____ Radiation ____ Other _____ None ____

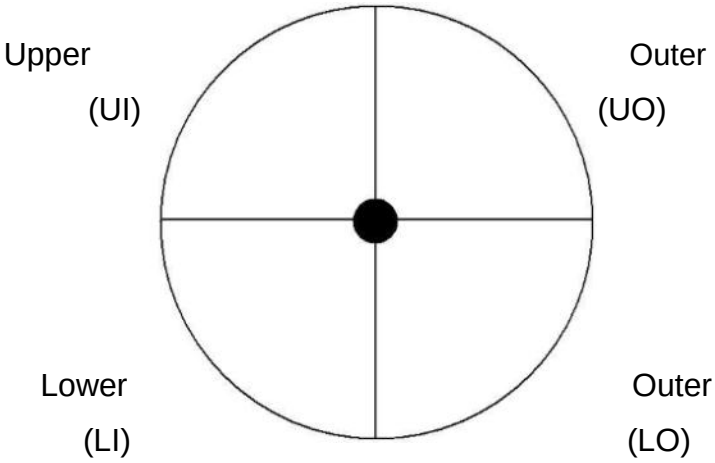
Other, please explain: _____

Breast biopsies or surgery: Please choose the area closest to the biopsy or surgery location based on the charts below. The exact location will be discussed and marked at your appointment. Extra scans will also be taken with a pointer to show the exact location for the doctor to review.

Left Breast



Right Breast



Where (left breast): UO ____
UI ____
LO ____
LI ____
Nipple ____

Where (right breast): UO ____
UI ____
LO ____
LI ____
Nipple ____

Diagnosed with other breast disease:

Disease type: Fibrocystic ____ Cystic ____ Mastitis ____ Abscess ____

Other, please explain: _____

(Please report other types of disease in the health history, thank you)

Patient Review of Body Systems

Constitutional

___ Fevers/Chills/Sweats

___ Unexplained weight loss/gain

___ Fatigue/weakness

___ Excessive thirst or urination

Musculo-Skeletal

___ Muscle or Joint Pain

___ Leg Pain with Exercise

Ears/Nose/Throat

___ Difficulty hearing/ringing

___ Hay Fever/Allergies

Cardiovascular

___ Chest Pain/Discomfort

___ Palpitations

Dental

___ Extractions

___ Crowns

___ Root Canal

___ Gum Disease

___ Fillings

___ Other _____

_____

Respiratory

___ Cough/Wheeze

___ Difficulty Breathing

Gastrointestinal

___ Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Large bowel dysfunction

Skin

_____ Rash or Mole

Neurological

___ Numbness

___ Headaches

Organ Dysfunction

_____

_____

Blood/Lymphatic

___ Unexplained Lumps

___ Easy Bruising

Other

_____

_____

_____

OB/GYN

___ Pap Smear Results: ___ Normal ___ Abnormal (please explain) _____

___ Hysterectomy - Date: _____ Bladder Infections: ____ Yes ____ No

___ Birth Control: ____ Yes ____ No If Yes: _____ Type _____ Amount

General Medical History: Past and Current medical problems (please include dates)

___ Heart Disease: (specify) _____

___ High Blood Pressure ___ High Cholesterol ___ Diabetes

___ Thyroid Problems ___ Kidney Disease ___ Asthma/Lung Disease

___ Chemical Exposure ___ Cancer: (specify) _____

___ Other: (specify) _____

Family History: Please indicate the current status of your immediate family members

(Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___ High Cholesterol ___ High Blood Pressure Other: _____

___ Heart Disease ___ Stroke _____

___ Bleeding or Clotting ___ Genetic Disorders _____

___ Asthma/COPD ___ Diabetes _____

___ Cancer: (type) _____

Signature: _____ Date: _____

MIDNIGHT SUN HEALING
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Midnight Sun Healing is required, by law, to maintain the privacy and confidentiality of yourprotected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice or associated with our practice for the purpose of treatment, payment or healthcare operations.

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers within or associated with **Midnight Sun Healing** for the benefit of providing you with more health care information.*

Payment

We email a receipt to you that can be sent to your insurance provider for the purpose of payment or health care operations.

> "*As a courtesy to our patients, we email an itemized receipt for you to submit to yourinsurance carrier for the purpose of showing payment to **Midnight Sun Healing** for health care services rendered. The receipt contains our business information, your name and address, type of scan, price of scan, form of payment and date of service. If more information is needed please call our office at 920.660.3320 and we will be happy to assist you.*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership.
In the event that **Midnight Sun Healing** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Midnight Sun Healing** is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that **Midnight Sun Healing** amend your protected health information. Please be advised, however, that **Midnight Sun Healing** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by **Midnight Sun Healing.**

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Midnight Sun Healing reserves the right to amend this Notice of Privacy Practices at anytime in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Midnight Sun Healing** is required by law to comply with this Notice.

Midnight Sun Healing is required by law to maintain the privacy of your health informationand to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: **Jacque Kress** by calling this office at 920.660.3320. If **Jacque Kress** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights or how **Midnight Sun Healing** has handled your health information should be directed to **Jacque Kress** by calling this office at 920.660.3320. If **Jacque Kress** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 01/01/2014.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **Midnight Sun Healing** with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

☐ I consent to give **Midnight Sun Healing** permission to email my report and images to me and or my doctor or health care provider.

Patient's Name (print)	Date
Patient's Signature	Date
Authorized Parent/Guardian (If under 18 years of age)	Date
Authorized Facility Signature	Date