INTEGRATED THERMAL IMAGING FORM

Rose Clinic, A Professional Medical Corp.
530 Lomas Santa Fe Drive Suite B-1 Solana Beach, CA 92075
Phone: 858-755-8955 Fax: 858-755-8959
www.roseclinic.us

All information given in this form will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Occupation:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )
Street address, cont'd:	Work phone no.: ( )	Cell phone no.: ( )

City:	State:	ZIP Code:	Email Address:

How did you hear about Rose Clinic?

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	❑ Internet

Other family members seen here:

PAYMENT INFORMATION

Payment is required in full for each visit. We are happy to provide you with coding information which you may submit to your insurance company for reimbursement. If you would like to keep a credit card on file for payments and or shipments please provide us with your credit card information.

Credit Card Number:	Expiration Date: / /	VISA, AMEX, MasterCard	Security Code:

Cardholder Name:	Signature:	Date: / /

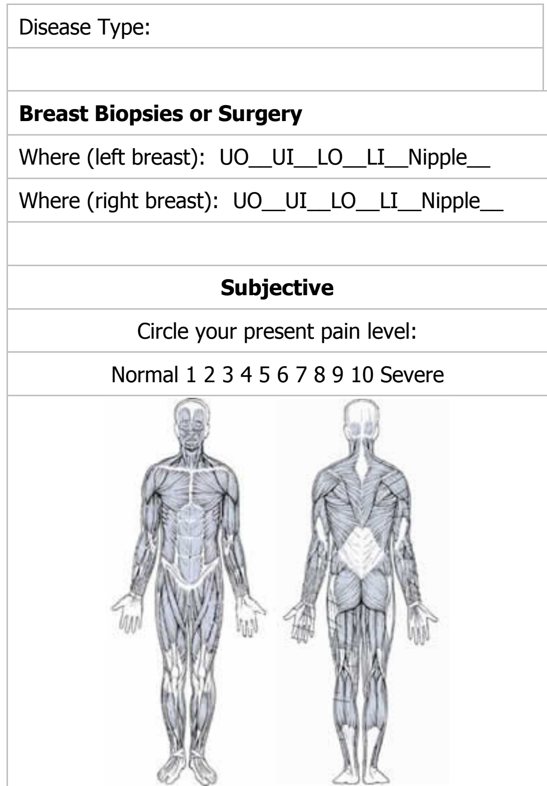
I authorize Dr. Jeanne Stryker to keep my signature on file and charge services and/or products on an ongoing basis. I understand this form is valid unless I cancel the authorization through written notice.

I have read the above billing information and give my consent for treatment at Rose Clinic.

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

Question	Yes	No
1. Do you have any close relatives who have 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?	❑ 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

Diagnosed with Breast Cancer
Cancer Type:
When Diagnosed: / /
Where (left breast): UO__UI__LO__LI__Nipple__
Where (right breast): UO__UI__LO__LI__Nipple__
Treatment:
Diagnosed with Other Breast Disease

9. Have you ever taken a contraceptive pill for more than 1 year?	❑ Yes ❑ No	Disease Type:
10. Have you suffered with cancer of the womb?	❑ Yes ❑ No	
11. Have you had a pharmaceutical hormone replacement therapy?	❑ Yes ❑ No	**Breast Biopsies or Surgery**
12. Do you have an annual physical examination by a doctor?	❑ Yes ❑ No	Where (left breast): UO__UI__LO__LI__Nipple__
13. Do you perform a monthly breast self exam?	❑ Yes ❑ No	Where (right breast): UO__UI__LO__LI__Nipple__
14. How many mammograms have you had in total?		
15. What was your age when you had your first mammogram?		**Subjective**
16. How many births have you had? Age of first child?		Circle your present pain level:
17. Did your periods start before the age of 12? Or finish by 50?		Normal 1 2 3 4 5 6 7 8 9 10 Severe
18. Do you smoke? ❑ Yes ❑ Never ❑ Not in last 12 months ❑ Not in last 5 years		
19. Have you recently had any of these breast symptoms?		
Pain	❑ Left ❑ Right	
Tenderness	❑ Left ❑ Right	
Lumps	❑ Left ❑ Right	
Change in breast size	❑ Left ❑ Right	
Areas of skin thickening or dimpling	❑ Left ❑ Right	
Secretions of the nipple	❑ Left ❑ Right	

HISTORY		
Previous illnesses:	Previous Surgery:	Medication:
Medications:		

Do you want a copy of the thermogram forwarded to your doctor? ❑ Yes ❑ No

INTEGRATED THERMAL IMAGING FORM

Rose Clinic, A Professional Medical Corp.
530 Lomas Santa Fe Drive Suite B-1 Solana Beach, CA 92075
Phone: 858-755-8955 Fax: 858-755-8959
www.roseclinic.us

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a Notice of Privacy Policies, from Jeanne Stryker MD detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the Privacy Practices describes the personal information your office collect and how and when your office use or disclose that information. It also describes my rights as they relate to any protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. If I do not accept this disclosure I understand that I must be notified when anything in my medical chart is going to be disclosed, to another physician or medical professional and that I must come in and sign for the medical release form of the items that are requested. I have listed below the following person(s) within my family or close friend(s) whom Dr. Jeanne Stryker can discuss my personal medical information with:

Name:	Relationship to patient:	Home phone no.:	Work phone no.:	Cell phone no.:
1.				
2.				
3.				
4.				
5.				

I accept my medical information may be disclosed under federal and state law. Additional Patient Disclosure: I understand that the Report generated from any images 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 of the areas discussed in the Report. By signed below, I certify that I have read and understand the statements above and consent to the examination.

I hereby authorize payment directly to Dr. Jeanne Stryker for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Dr. Jeanne Stryker and/ or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature:	Date
Print Name:	Date
Reviewed by:	Date

SERVICE FEES

Description	Charges	Payments	Adjustments	Balance
Services	**Fees**		Date of Service:	
Head and Face	$150			
Lymph/Breast	$175		Place of Service:	
Visceral	$125			
Cranial/Jaw	$125		Date of Accident:	
Upper Extremity	$250			
Lower Extremity	$250			