

PATIENT INFORMATION FORM



It is important that you provide your complete and current information.
Please present your insurance card(s) and photo ID.

MRN: _____

Today's Date: _____ ☐ New Patient

Patient's Name: _____ Date of Birth: _____
(Per Insurance Card)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address: _____ Preferred Language: _____

Preferred Method of Notification: ☐ Mail ☐ Phone ☐ Email ☐ Mobile

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other Sex: _____

Referring Physician: _____ Phone: _____

Ethnicity: ☐ Unknown ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Smoking Status ☐ Every Day ☐ Some Days ☐ Former ☐ Never

*Allergies: _____

*Medications: _____

**Allergies and medications which do not affect imaging studies may not be recorded or displayed.*

How did you hear about us? _____

Notify in Emergency: _____ Phone: _____

Relationship to You: _____

Primary Insurance Information

For Medical Patients: Are You or Your Spouse Working? ☐ Yes ☐ No If Yes, whom? _____

Primary Insurance Name: _____ Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy # _____ Group # _____ DOB: _____

Policy Holder Name: _____ Sex: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Patient's Relationship to Policy Holder: _____

Secondary Insurance Information

For Medical Patients: Are You or Your Spouse Working? ☐ Yes ☐ No If Yes, whom? _____

Primary Insurance Name: _____ Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy # _____ Group # _____ DOB: _____

Policy Holder Name: _____ Sex: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Patient's Relationship to Policy Holder: _____

PATIENT AUTHORIZATION



Patient's Name: _____ DOB: _____ MRN: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Email Address: _____

Phone Number: _____

CONSENT FOR TREATMENT:

I hereby give my consent for Women's Center for Radiology, PA to perform the diagnostic test(s) as prescribed by my referring physician.

RELEASE AUTHORIZATION/PRIVACY PRACTICES (HIPAA):

I hereby authorize Women's Center for Radiology, PA to request and/or release pertinent information and copies of medical records to/from other health care providers or physicians to assure continuity of care; to/from third party payers, review agencies or insurance companies in order to process reimbursement for services I receive. This includes my employer for the purposes of processing a Workman's Compensation claim. If I revoke permission, Women's Center for Radiology, PA will stop releasing information unless bound by law, I acknowledge receipt of a copy of the Women's Center for Radiology, PA Notice of Privacy Practices. Due to laws regulating confidentiality and communications, we need your authorization to contact you for appointments and administrative matters. Methods of contact may include using prerecorded/artificial voice messages and/or use of automated dialog devices, via telephone, cellular, email, text and voicemail.

FINANCIAL RESPONSIBILITY:

I, the undersigned, do hereby assume full responsibility for the payment of services rendered. Furthermore, I assign my insurance benefits, in connection with all services rendered by Women's Center for Radiology, PA I understand that I shall be responsible for any service that is not covered in part or as a whole by my insurance. Should the account be referred to collections the undersigned shall pay all attorney fees and collection expenses. Balances over ninety (90) days are subject to a late charge of 1.5% per month (annual percentage 18%).

Coverage of Breast cancer screening is usually covered by most insurance companies as part of your well women care. If your physician has ordered a diagnostic mammogram and/or breast ultrasound, this coverage is not considered preventive care, and your insurance company may apply these imaging studies to your deductible. Please contact your insurance company if you have any coverage/deductible questions.

PATIENTS WITH MEDICARE / MEDICAID / LIFETIME SIGNATURE ON FILE:

If applicable, I certify that the information I provided in applying for release under Title XVIII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information to be released to the Social Security Administration or its intermediaries or carriers any information needed to this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I authorize the above named provider to submit to Medicare and/or Medicaid for payment on my behalf. I assign the benefits payable for diagnostic services to Women's Center for Radiology, PA.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING PERSON(S):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

BREAST HISTORY

Patient's Name: _____ DOB: _____ Age: _____ Patient ID: _____

Please Complete to Evaluate Your Risk Assessment:

Age menstruation began: _____ Your age at first live birth: _____ Menopause Age: _____ Weight: _____ Height: _____

Hormone Replacement Therapy ☐ Yes ☐ No

Ashkenazi Jewish Ancestry ☐ Yes ☐ No

Any Symptoms ☐ No

Lump ☐ Yes ☐ Right ☐ Left

Nipple Discharge ☐ Yes ☐ Right ☐ Left

Pain / Soreness ☐ Yes ☐ Right ☐ Left

Skin Changes ☐ Yes ☐ Right ☐ Left

Other Concerns ☐ Yes ☐ Right ☐ Left

Notes:

Your Personal History

Breast Cancer ☐ Yes ☐ Right ☐ Left Age: _____

Lumpectomy ☐ Yes ☐ Right ☐ Left Age: _____

Mastectomy ☐ Yes ☐ Right ☐ Left Age: _____

Radiation / Chemo ☐ Yes ☐ Right ☐ Left Age: _____

Tamoxifen or current treatment: _____

Radiation to your chest between ages 10-30 for Lymphoma / Hodgkin's ☐ Yes

Breast Biopsy

Cyst Aspiration ☐ Right ☐ Left # _____ Age: _____

Core Biopsy ☐ Right ☐ Left # _____ Age: _____

Breast Surgery

Excisional Biopsy ☐ Right ☐ Left # _____ Age: _____

Atypical Hyperplasia ☐ Right ☐ Left # _____ Age: _____

Lobular Hyperplasia ☐ Right ☐ Left # _____ Age: _____

Reduction / Lift ☐ Yes # _____ Age: _____

Implants: Saline / Silicone ☐ Yes ☐ No # _____ Age: _____

Implants Removed ☐ Yes # _____ Age: _____

Other: _____

Known Family History		
Relationship	Age at DX	History
N/A	N/A	N/A

Family History of Breast Cancer

Mother ☐ Yes Age: _____ Aunt(s) M/P ☐ Yes Age(s): _____

Sister(s) ☐ Yes Age(s): _____ Cousin(s) M/P ☐ Yes Age(s): _____

Daughters(s) ☐ Yes Age(s): _____ Male Relatives M/P ☐ Yes Age(s): _____

Grandmother(s) M/P ☐ Yes Age(s): _____ Other Relatives M/P ☐ Yes Age(s): _____

Have you had Genetic Testing ☐ Yes Results: _____

Relatives Genetic Testing ☐ Yes Results: _____

Personal Cancer:

Ovarian ☐ Yes Age: _____

Uterine ☐ Yes Age: _____

Thyroid ☐ Yes Age: _____

GYN ☐ Yes Age: _____

Other: _____ Age: _____

Relatives with cancer:

Patient Signature: _____ Date: _____

For office use:



Prior: _____ Release Signed: _____ Pregnant: _____ Breast Feeding: _____ Tyrer Cuzick: _____

Notes: _____