PATIENT INFORMATION FORM

Women's Center For Radiology | SOLIS Mammography

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

Women's Center For Radiology | SOLIS Mammography

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 while 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

Women's Center For Radiology | SOLIS Mammography

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

Notes:

Lump	☐ Yes	☐ Right	☐ Left	
Nipple Discharge	☐ Yes	☐ Right	☐ Left	
Pain / Soreness	☐ Yes	☐ Right	☐ Left	
Skin Changes	☐ Yes	☐ Right	☐ Left	
Other Concerns	☐ Yes	☐ Right	☐ Left	

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

Excisioinal 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:

_____

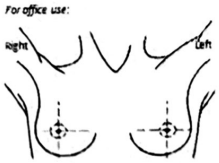
_____

_____

_____

_____

Patient Signature: _____ Date: _____



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

Notes: _____