



The Heart of Great Medicine

MOBILE MAMMOGRAPHY PATIENT INFORMATION QUESTIONNAIRE

Hospital Use Only
Employer
Insurance
Date & Time Mammogram scheduled:
Location:

Thank you for choosing St. Bernard's Medical Center for your healthcare needs. To expedite your registration please complete the following questionnaire:

Section 1 Patient Information

Full Legal Name:
Street Address:
Mailing Address:
Date of Birth:
SS#:
Maiden Name:
Spouse Name:

Have you received medical care from St. Bernard's under any other name? Yes No

Who to contact in case of emergency?

Name: Phone # Relationship:

Section 2 Employer and Spouse Information

Occupation: Employer:
Employer Address: Employer Phone #:
Spouse Name: SS#: Employer:
Spouse Employer Address: Employer Phone #:

Section 3 Insurance Information

As a courtesy St. Bernard's will bill your insurance. you will be responsible for anything that your insurance does not cover. It is not necessary to complete this section if your Employer is responsible for today's mammogram charges.

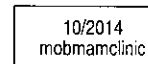
(1) Insurance: Subscriber:
Policy #: Group #:
(2) Insurance: Subscriber:
Policy #: Group #:

Section 4 Release of Information

I hereby authorize St. Bernard's Medical Center to supply the Employee Health Clinic at or other medical related facility, insurance company or other organization who have a legitimate need, information regarding my health status and any and all breast care services related to this visit.

I hereby assign my insurance benefit to St. Bernard's Medical Center.

Signature:



For Office Use Only:



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Women's Diagnostic Center  
1144 East Matthews, Jonesboro, Arkansas 72401

### PERSONAL RISK QUESTIONNAIRE

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Have you received care under another name: \_\_\_\_\_  
Doctor: \_\_\_\_\_ Last appointment with Doctor: \_\_\_\_\_  
When was your last physical breast exam with doctor? \_\_\_\_\_  
Have you had a previous mammogram?  Yes  No  
Where was your last mammogram? \_\_\_\_\_  
When was your last mammogram? \_\_\_\_\_ When was your last menstrual period? \_\_\_\_\_  
Age at first menstruation \_\_\_\_\_ Menopause age? \_\_\_\_\_ Reproductive surgery (date/type) \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Age at first delivery \_\_\_\_\_

#### Do you have any of the following symptoms?

	Left Breast	Right Breast	How Long (for each symptom)
1. Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pain/Tenderness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Nipple Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	color: _____
4. Nipple Inversion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

#### Have you had any of the following?

	Left Breast	Right Breast	When was your surgery
1. Surgery/Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
2. Cyst aspiration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

#### Please mark all that apply to you.

Are you taking hormones or birth control pills?  Yes  No How long? \_\_\_\_\_  
Have you every had any type of cancer?  Yes  No Type? \_\_\_\_\_  
Chemotherapy  Yes  No  
Radiation  Yes  No

#### 3. Strong Family History of Breast Cancer.

Mother – Age when diagnosed \_\_\_\_\_  
Sister – Age when diagnosed \_\_\_\_\_  
Daughter – Age when diagnosed \_\_\_\_\_  
Other relative \_\_\_\_\_



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### Patient Request for Release of Information

PATIENT NAME: \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_

HEALTHCARE PROVIDER: \_\_\_\_\_

#### FILL OUT THIS SIDE IF RECORDS WILL BE RELEASED TO PATIENT OR PERSONAL REPRESENTATIVE:

I hereby request that the Healthcare Provider release the information outlined below to me.

#### METHOD OF DELIVERY:

- Pick Up
- E-mail records to me at: \_\_\_\_\_

Mail records to me at the following address: \_\_\_\_\_

Other: \_\_\_\_\_

#### FORMAT OF RECORDS:

- Paper
- Electronic

#### INFORMATION TO BE RELEASED:

The type and amount of information to be used or disclosed is as follows: \_\_\_\_\_ Date(s) of service \_\_\_\_\_

- Entire medical record
- History/physical
- Discharge summary
- Consultation report
- Operative report
- Progress notes
- Nurses notes
- Medication records
- Laboratory results
- X-ray results

- Itemized statement
- Physician's orders

Other (Please specify): **IMAGES ARE FOR COMPARISON**

- Mammograms with Reports
- Breast Ultrasounds with Reports
- Breast biopsy with Reports
- Breast Pathology Reports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**Warning and Assumption of Risks:** In the event that I specifically request to receive the information in an unencrypted format and do not agree to receiving the information in a secure encrypted format, I understand that the information will not be secure. The risk associated with receiving information in an unsecured format (including an unencrypted flash drive or CD) include, but are not limited to, an unauthorized person or entity accessing or using the information. By demanding that my information be disclosed in an unsecure format, I acknowledge that I have been warned of and accept such risks.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
If signed by Personal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness