SWDC1278

St. Bernards MEDICAL CENTER
The Heart of Great Medicine

MOBILE MAMMOGRAPHY PATIENT INFORMATION QUESTIONNAIRE

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

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

Section 1 Patient Information

Full Legal Name: _____, _____, _____
Last First Middle

Street Address: _____ City: _____ State: _____ ZIP: _____ Phone #: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth: _____ Race: _____ Sex: _____ Marital Status: S___ M___D___W___

SS#: _____ Physician: _____

Maiden Name: _____ Spouse Name: _____
If applicable *If applicable*

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: _____
Full Legal Name

Spouse Employer Address: _____ Employer Phone #: _____

Section 3 Insurance Information

As a courtesy St. Bernards 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: _____, _____, _____
Last Name First Name Middle Initial

Policy #: _____ Group #: _____ Subscriber SS#: _____

(2) Insurance: _____ Subscriber: _____, _____, _____
Last Name First Name Middle Initial

Policy #: _____ Group #: _____ Subscriber SS#: _____

Section 4 Release of Information

I hereby authorize St. Bernards 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. Bernards Medical Center.

Signature: _____

10/2014
mobmamclinic

For Office Use Only:

St. Bernards MEDICAL CENTER
The Heart of Great Medicine
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	☐ Yes ☐ No	☐ Yes ☐ No	_____
Pain/Tenderness	☐ Yes ☐ No	☐ Yes ☐ No	_____
3. Nipple Discharge	☐ Yes ☐ No	☐ Yes ☐ No	color: _____
4. Nipple Inversion	☐ Yes ☐ No	☐ Yes ☐ No	_____

Have you had any of the following?

		Left Breast	Right Breast	When was your surgery
1. Surgery/Biopsy	☐ Yes ☐ No	_____	_____	_____
2. Cyst aspiration	☐ Yes ☐ 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 _____

SPOC8090

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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

FILL OUT THIS SIDE IF RECORDS WILL BE RELEASED TO A THIRD PARTY:

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

Name: St. Bernards Imaging Center
E-mail: 1144 E. Matthews Ave.
Address: Jonesboro, AR 72401
Phone: 870-207-8000
Fax: 870-207-0541

METHOD OF DELIVERY:
☐ Pick Up
☐ E-mail to email listed above
☒ Mail to address listed above
☐ Other: _____

FORMAT OF RECORDS:
☐ 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	☐ Progress notes	☐ Itemized statement
☐ History/physical	☐ Nurses notes	☐ Physician's orders
☐ Discharge summary	☐ Medication records	☒ Other (Please specify): IMAGES ARE FOR COMPARISON
☐ Consultation report	☐ Laboratory results	Mammograms with Reports
☐ Operative report	☐ X-ray results	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