Mammos On The Move

BE PREPARED FOR YOUR MAMMOGRAM APPOINTMENT

To ensure a positive experience when arriving for your mammogram, please have the following items with you:

- Insurance Card
- Driver's license or other picuture ID
- Doctor's order if applicable
- Physician's Name
- Name of facility where you had your previous mammogram

Remember: Do not wear any deodorant or talcum powder the day of your appointment.

If possible and for your comfort, we suggest you wear a two piece outfit the day of your appointment.

Mammos On the Move at DESERT IMAGING

Patient Account #_____

Patient History Form

Date of Birth _____ Today's Date _____

Name (Last) _____ (First) _____ (MI) _____

Referring Physician _____ MD ☐ DO ☐ NP ☐

Family Breast Cancer History:

Have you or your relatives **listed below** ever been diagnosed with breast cancer? Yes _____ No _____

Self _____ Age _____ Mother _____ Age _____ Sister _____ Age _____

Grandmother _____ Age _____ Aunt _____ Age _____ Daughter _____ Age _____

Have you had a previous mammogram? _____ Location _____

Age of last menstrual period _____ Age started menstrual cycle _____

Number of pregnancies you have had _____ Have you undergone menopuase? _____

Ovaries been removed? _____ If yes, when? _____ Do you take hormones? _____

Name of hormone supplement(s) _____ Taken for how long? _____

Patient Signature X _____

Tech Signature _____

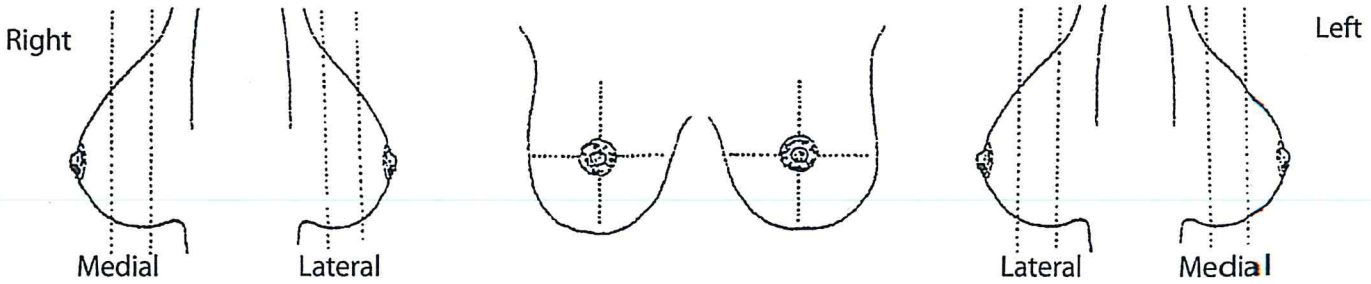
Procedures:

Have you had breast cancer? _____ Right or Left Date/Explain _____

Breast Biopsy	_____	Right or left _____	Date/ Explain _____
Aspiration	_____	Right or left _____	Date/ Explain _____
Lumpectomy	_____	Right or left _____	Date/ Explain _____
Reduction	_____	Right or left _____	Date/ Explain _____
Mastectomy	_____	Right or left _____	Date/ Explain _____
Implants	_____	Right or left _____	Date/ Explain _____

Current Symptoms: (Technologist will complete)

Mass or lump:	Description	_____
Discharge:	Description	_____
Enlargement/swelling:	Description	_____
Tenderness/pain:	Description	_____
Nipples retracted:	Description	_____
Dimpling of breast:	Description	_____
Axillary masses:	Description	_____
Other:	Description	_____



MAMMOGRAPHY QUESTIONNAIRE

PATIENT REGISTRATION

PATIENT INFORMATION

Patient#:	***Gender:**	***Date of birth:**
***Last Name:**		***Age:**
***First Name:**	**Initial:**	***Social Security #:**
***Address:**		***Home Phone:**
***City, State, Zip:**		***Work Phone:**

RESPONSIBLE PARTY

Account #	Patient Relationship to Guarantor:	
Last Name:		Gender: Marital Status:
First Name:		Date of Birth:
Address:		Social Security:
City, State, Zip:		Home Phone:
Employer: Employer Address:	Work Phone: City, State Zip:	

INSURANCE INFORMATION

Primary Insurance:		Policy/Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
Second Insurance:		Policy/Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/Legal Guardian Name:	***Emergency Contact:**
Address(if different than patient):	***Address(if different than patient):** ***Patient relationship to Contact:**
Parent Home Phone:	***Contact Home Phone:**
Parent Work Phone:	***Contact Work Phone:**

MISCELLANEOUS INFORMATION

Name of Nearest Relative not living w/you: Phone:	Who is your Primary Care Physician? Phone:
What are you being seen for? If Injury, due to an accident? ☐ Yes ☐ No What type of accident? ☐ Auto Accident ☐ Job Related Date of Accident: / /	Who referred you to us? Phone: Is this visit for a second opinion? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Desert Imaging to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative I understand that I am financially responsible to said doctors for all charges. I hereby authorize this practice to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

***Signature** X _____ ***Date:** _____

Mammos On the Move

at DESERT IMAGING

SELF-REQUEST
PATIENT CONSENT

I, _____ am presenting myself to M.O.M. Services as a **"Self Request" patient** for a screening digital mammogram. I have read and agree to the following.

1. I currently have a personal physician and understand that Desert Imaging will forward the mammography result to my physician.

2. Please forward my mammography results to my physician, _____
   Physician Name

3. **I further agree and understand that as a self-requesting patient it is my responsibility to schedule an appointment and follow up with my physician, in a timely manner, regarding the findings detailed in my mammography results and comply with the recommendations made by my physician.**
4. I am aware that most health insurance companies offer coverage for a screening mammography at a rate of one screening per year (366 days).
5. I am also aware that the mammography study that I will be receiving is for screening purposes only and not for a diagnostic exam.

_____ _____
Patient Signature Date

_____
Hostess

Mammos On the Move
at DESERT IMAGING

Mammography Film Release Form

Information for Patient

Thank you for choosing to schedule your Mammogram with **Mammos on the Move (MOM).** After the mammogram is performed, a qualified Radiologist will read your images. To provide you with the best quality of care, we would like you to request your most recent mammogram from the prior facility. You will need to complete this form then FAX or Mail to your prior facility's mammography department, PREFERABLY 2 weeks prior to your scheduled appointment to ensure they arrive in a timely manner. If previous films are not available at the time of your appointment, your reading may be delayed until comparison studies arrive.

Acceptable Methods of obtaining images:

- ☐ **Digital CD's**
- o **Patient to pick-up from local facilities**
- o **Mail to: Please send all CD's and/or Films to our Main Location:**

Mammos On The Move
512 Victoria Ln. Ste 1-B
Harlingen, Texas 78550
844-306-2666 FAX 888-263-4112

Patient Name _____ Date of Birth _____

Date_____ Account# _____

Facility of Last
Mammogram _____

Phone_____ FAX _____

I am requesting a copy of my previous mammogram and/or breast ultrasound Images to be released from the above entity. As the person signing this consent, I understand that I am giving permission to the above named provider for disclosure of confidential health care records. I understand that these records will be used by MOM, Inc. providers and/or contracted providers for the purpose of comparison to current mammographic studies. Contractual providers are bound to confidentiality requirements as stated in the MOM patient privacy statement in accordance with HIPAA regulations. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included in my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless recipient is a provider who makes disclosures permitted by law.

Patient Signature _____ Date _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Desert Imaging's Notice of Privacy Practices.

By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

THE ABOVE DOCUMENT IS AVAILABLE ON THE "MOM" MAMOGRAPHY MOBILE UNIT, THE DAY OF YOUR SCHEDULED EXAM.