REGISTRATION FORM **MRN:**

Section I **Patient Information** **Date**_______________

Legal Name:____ Mobile site location: _________________________
Address:____City:_______________State:_________Zip_______________
Phone (______)_________________ Work Phone (_____) _______________ Cell Phone (______)___________________

The best time to contact me is: ☐ A.M. ☐ P.M. on my ☐ Home ☐ Work ☐ Cell May we leave a message: ☐ Yes ☐ No
Date of Birth:_______________ Last four digits of Social Security Number(optional):_____________________________
Your e-mail address:____
Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer:_____________________________ Employer address____
Occupation_________________ Whom may we thank for referring you?_______________________________________
Person to contact in case of emergency__________________________________ Phone__________________________
Address____ ____

Section II **Physician Information**

Name of Primary care physician or OB/Gyn:____
Address:____City:____________________________________
State:__________ Zip:_____________ Phone: (____)____________________ Fax: (____)__________________________

Appointment Time Preference

Please list your preferred appointment time between 8:30am and 3:45pm, we will schedule in the order we receive.

1.	2.	3.

Section III **Insurance Information**

Name of Insured________________________________DOB______________Relationship to Patient ________________
Name of Employer:____________________________ Work Phone: (____)____
Address of Employer:___________________________________City_________________State:________Zip ___________
Insurance Company__________________________ Group #_____________________ ID#__________________________
Ins Co Address:____ Ins Co. Phone:___________________________

------------ *DO YOU HAVE ANY ADDITIONAL INSURANCE?* ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING* ------------

Name of Insured________________________________DOB______________Relationship to Patient ________________
Name of Employer:____________________________ Work Phone: (____)____
Address of Employer:___________________________________City_________________State:________Zip ___________
Insurance Company____________________________ Grp #_____________________ ID#__________________________
Ins Co Address:____ Ins Co. Phone:___________________________

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University Health System | Breast Health Services

What is the REASON you are having a breast imaging exam (please select one)?
☐ This is a routine (screening) exam. I am not having any breast problems.
Do you have any of the following?
☐ I am going to have a breast reduction, but I am not having problems.
☐ I have implants, but I *am not* having problems.
☐ I have implants, *I am* having problems. ☐ Right side ☐ Left side

I am having the following problem(s): Circle R for Right or L for Left	
R L __Bloody discharge*	*R L* __Cancer elsewhere
R L __Image detected calcifications*	*R L* __Large nodes under my arm*
R L __Nipple problem*	*R L* __Pain in the breast
R L __Other skin changes to breast*	*R L* __Skin thickening or retraction on clinical examination*
R L __Implant problem	*R L* __Image detected mass*
R L __Other lump or thickening*	*R L* __Palpable abnormality or lump*
R L __Bloody discharge*	*R L* __Cancer elsewhere
***If you are having any of the above problems (*), please call a Patient Navigator at 358-3720 and she will help you schedule a more appropriate exam. You are not a candidate for a mobile mammography screening.**	

Check all of the following RISK FACTORS that are true for you:	
__I do not know my personal breast cancer history	__I have been through menopause
__I have had breast cancer*	__I have never had children
__I have had endometrial cancer	__I had my first child after age 30
__I have had ovarian cancer	__I have BRCA1 gene mutation
__I have had previous chest radiation	__I have BRCA2 gene mutation
__I have had a previous breast biopsy that showed a high risk lesion.	
***If you have a personal history of breast cancer (*), please call a Patient Navigator at 358-3720 and she will help you schedule a more appropriate exam. You are not a candidate for a mobile mammography screening.**	

History of previous breast PROCEDURES: (Breast reduction, Cyst aspiration, Core biopsy, Excisional biopsy, Implant removal, Lumpectomy*, Mastectomy*, Radiation therapy to the breast*, Reconstruction*, Other type of biopsy)			
Procedure	Side	Date performed	Outcome
Procedure	Side	Date performed	Outcome
***If you have a personal history of breast cancer (*), please call a Patient Navigator at 358-3720 and she will help you schedule a more appropriate exam. You are not a candidate for a mobile mammography screening.**			

Family History	
If you have a family history of *breast cancer*, please indicate the family member and age of diagnosis. First degree family members only (mother, sister, daughter, etc).	
Family member:	Age diagnosed:
Family member:	Age diagnosed:

Signature
My signature indicates that I have completed the above information and registration form.
Signature:____ Date:___________________________

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University Health System | Breast Health Services

Previous mammograms
Have you had a previous mammogram? ☐ Yes ☐ No Facility Name____

CONSENT TO RELEASE INFORMATION

Please complete the following *Consent to Release Information* form so that we can *request your previous mammogram images* and reports. This information is not required to schedule your mammogram; **however our radiologists prefer to have previous films at time of the screening mammogram for comparison purposes**.

Additionally, by my signature I hereby authorize (name and address of facility)_________________________________ to disclose records concerning (legal name of patient) ____________________________________(Date of Birth)__________

To: University Healthy System- Breast Imaging and Intervention
7979 Wurzbach Rd Suite Z500 San Antonio, Texas 78229
Phone : (210) 450-5050 Fax: (210)450-5629

I understand that the information is needed or will be used for the following purpose: ***comparison*** and will be limited to the following specific types of information: **Mammograms and breast ultrasound images and reports.**

To the party receiving this information: This information is disclosed from the records whose confidentiality is protected by Federal law. Federal regulations (42CFR, Part 2) prohibit further disclosure without specific written consent of the person to whom it pertains. A general authorization for release of medical information is not sufficient for this purpose.

I understand that information relevant to HIV Testing or AIDS related diagnosis may be contained in this information.

I, the undersigned, understand this information may include reference to psychiatric treatment or treatment for substance abuse. The hospital, employees and physicians are released from liability for release of this information. This consent is valid for 90 days.

Patient signature:____Date:_______________________________

Please save document with your last name, first initial and return to mobilereq@uhs-sa.com or fax to 210-358-3631. A UHS staff member will call you to review information and provide you with an appointment within 3-5 days of receipt.

For Office Use Only

Financially cleared ☐ Yes ☐ No ☐ Private Insurance ☐ Medicare/Medicaid ☐ Grant Funded
Patient Notified ☐ Yes ☐ No Notes:____
Initials: _________________Date:________________________