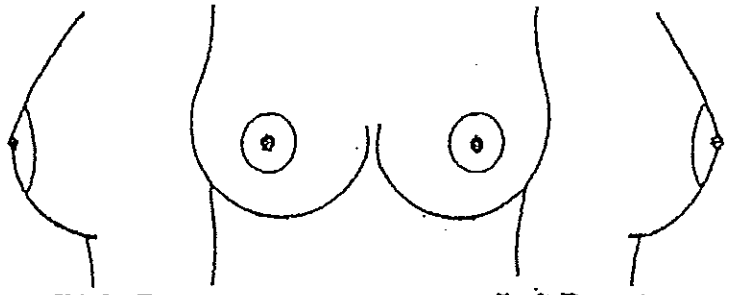
Mammography History and Pregnancy Form

Patient Name:_____Date:_____Age:_____

First day of last menstrual period?	_____
Are you pregnant?	Yes / No
Age at first pregnancy?	_____
How many pregnancies have you had?	_____
Age of first menstrual cycle?	_____
Do you take hormones?	Yes / No
Do you have pain or tenderness in breast?	Yes / No
Do you have a lump in your breast?	Yes / No
Have you noticed any skin or nipple change?	Yes / No
Do you have discharge from your nipples?	Yes / No
Have you had breast biopsy/ surgery?	Yes / No
Have you had breast cancer?	Yes / No
Have you had a breast removed?	Yes / No
Do you have a family history of breast cancer?	Yes / No
If so, who?	_____
Do you have implants?	Yes / No

Have you had a previous mammogram? Yes / No .....Where?_____

Please mark area of concern



Right Breast **Left Breast**

The radiation used in Mammography may be harmful to an unborn child. To prevent accidental irradiation, we require the following information of female patients of child bearing ages in accordance with national standards.

I, (patient's name)_____, have been fully informed of the risks involved in radiation and assume the responsibility for any consequences from the procedure(s) I am about to have. I understand that I will not hold Imaging Specialists of Charleston and its employees responsible for any potential harm to myself or my unborn child.

Patient Signature:_____

Mammography Technologist Signature:_____

Imaging Specialists

PATIENT INFORMATION	UPDATED INFORMATION
MRN#	
Name	
DOB	
Address	
City, State, Zip	
Social Security #	
Home Phone #	
Work/ Mobile Phone#	
Email Address	
Policy Holder	
Relationship	
Guarantor DOB	

SCHEDULED EXAM:

Ref. Physician _____

Ref. Physician Phone _____

Additional Physicians:

Physician / Phone # _____

I understand that I am responsible for my bill and any charges or charge balances not paid by my insurance. I understand that there will be a fee of $35.00 for any checks returned for insufficient funds. I authorize payment direct to my physician. I authorize use of all medical information to process this claim. I authorize the qualified medical personnel of this facility to perform this procedure.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE DATE

Imaging Specialists

MEANINGFUL USE FORM

PATIENT NAME: DOB: MRN:

Meaningful Use Defined:

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Meaningful use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino **Preferred Language:** _____

Please indicate any Family Health History -

Mother_____ **Father**_____

Sister_____ **Brother**_____

Race: (Please check one)

□ American Indian or Alaska Native □ Asian □ Black or African American □ Caucasian

□ Pacific Islander or Native Hawaiian □ Other

Smoking Status: (Please check one)

□ Current everyday □ Current some day smoker □ Former smoker □ Never smoker □ Unknown

Height: **Weight :** **Blood Pressure:** _____

Please list any known allergies (Include reaction):

_____

_____

Please list your current medications :

_____

_____

Imaging Specialists

PATIENT RIGHTS AND AUTHORIZATION

PATIENT NAME: **DOS:** **MRN:**

A. Patient Rights: Please check the appropriate box below:

☐ I have been informed of my patient rights.

☐ I have been offered a written copy of my patient rights

B. Authorization to Release Medical Information to Family Members/Friends:

I give permission to Imaging Specialists to release information regarding appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number, healthcare information, and treatment to the following individuals:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

PLEASE CHECK HERE IF YOU DO NOT WISH TO LIST ANYONE ☐

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE DATE

_____

PRINT NAME OF ABOVE SIGNATURE