

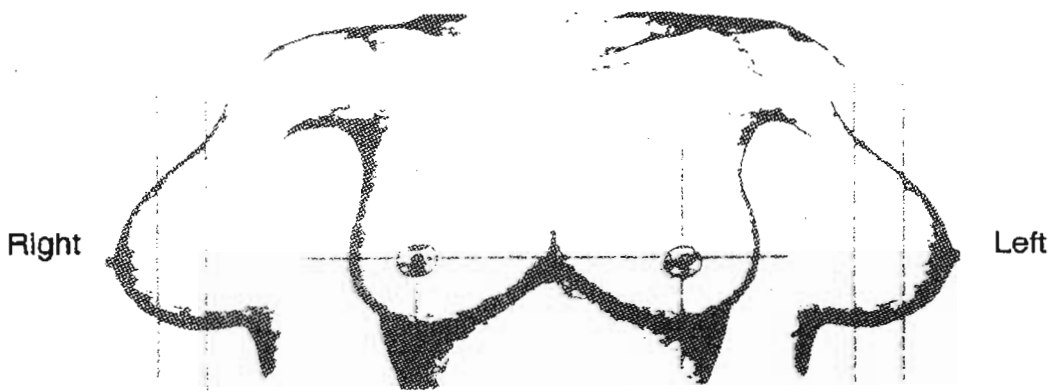
| | | | | |
|----------------------|------------|-----------------------|------------------------|------------------------|
| File No. | Date | Appt. Time | Accession # | Computer # |
| Patient Name Last | First | MI | Area Code Home Phone | |
| Address (Apt. No.) | City | State | Zip Code | Social Security Number |
| Age | Race | You Chose Us Because: | Physician | Date of Birth |
| Patient's Employer | Work Phone | Cell Phone | Insurance Company Name | |

- 1) Please circle history of **breast cancer**: None Myself Mother Sister Daughter Grandmother Aunt Father Brother
- 2) Please circle history of **ovarian cancer**: None Myself Mother Sister Daughter Grandmother Aunt
- 3) How many children have you given birth to? ____ How old were you when you had your 1st child? ____ Currently Breastfeeding? Yes No
- 4) Do you currently take hormones or birth control? If so, number of years taken? _____
- 5) When was your last menstrual cycle OR how old were you at menopause? _____
- 6) Have you had any breast surgeries or biopsies? If so, what breast, what year and what type? _____
- 7) Do you have breast implants? _____ If so date of surgery: _____
- 8) When was your last physical breast exam by a doctor? _____ Dr. _____
- 9) Was your last mammogram with our facility (OBCC) or our mobile van? Yes No
- 10) Other than our facility, where and when was your previous mammogram done?

OFFICE USE ONLY

Breast pain _____
 Breast lumps _____
 Nipple discharge _____

| |
|----------------------------------|
| MRI (prev) _____ |
| SCREEN DIAGNOSTIC |
| LKK PAD PJM _____ |
| <input type="checkbox"/> Consult |



MAMMO (please circle and fill in # of views) SCR ____ Views DX ____ Views U/S L R Breast Exam L R

| | Full | FS | Mag | Lat | XCC | Other | |
|---|------|----|-----|-----|-----|-------|---|
| L | | | | | | | L |
| R | | | | | | | R |

Consultation
1 2 3 4

Tech. Int. Mg _____
 Us _____
 Rad Int. Bx _____

INFORMED CONSENT

- 1. I AUTHORIZE THE OKLAHOMA BREAST CARE CENTER (OBCC) TO RELEASE OR REQUEST COPIES OF MEDICAL RECORDS AND X-RAY PERTINENT TO THE COURSE OF MY EXAMINATION.**
- 2. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES RESULTING FROM THIS VISIT.**
- 3. I HAVE BEEN INFORMED THAT SOME INSURANCE CARRIERS WILL ONLY PAY FOR ONE SCREENING MAMMOGRAM EVERY 365 CALENDAR DAYS.**
- 4. I AM AWARE THAT ANY DIAGNOSTIC STUDIES MAY BE SUBJECT TO MY DEDUCTIBLE AND/OR NOT COVERED AS DICTATED BY MY INSURANCE POLICY.**
- 5. IT IS THE POLICY OF OBCC THAT ANY CHARGES OVER 90 DAYS REQUIRE A MINIMAL MONTHLY PAYMENT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**
- 6. IF I ELECT TO HAVE MY INSURANCE FILED BY OBCC, I GIVE IRREVOCABLE AUTHORIZATION THAT THIS BE DONE WITH SIGNATURE ON FILE. A PHOTOSTATIC COPY WILL SERVE AS THE ORIGINAL.**
- 7. I AM AWARE THAT EFFECTIVE APRIL 14, 2003 I HAVE ACCESS TO THE PATIENT'S PRIVACY NOTICE ENFORCED BY OKLAHOMA BREAST CARE CENTER UPON REQUEST.**
- 8. I AUTHORIZE OBCC TO MAIL INFORMATION TO ME USING COMPANY LOGO; AND TO IDENTIFY THEMSELVES WHEN LEAVING A TELEPHONE MESSAGE.**

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE

IF YOU HAVE REQUESTED FILMS TO BE SENT TO US FROM A PRIOR FACILITY, PLEASE NOTIFY THE RECEPTIONIST.