

The Rose Mobile Mammography Medical History Form

ID# _____ SCREENING DATE: _____ LOCATION: _____ MEHOP _____

NAME: _____ DOB: _____ AGE: _____
First, M., Last

Referring Physician Information:

Name _____ Address _____ City _____ ST _____ Zip Code _____

MEDICAL HISTORY

WHAT IS YOUR AGE? _____ (ANYONE UNDER AGE 34 AND UNDER CANNOT BE SEEN ON MOBILE)

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU PREGNANT? YES NO DATE OF LAST MENSTRUAL PERIOD: _____

ARE YOU CURRENTLY BREASTFEEDING? YES NO

DO YOU HAVE ANY LUMPMASSES IN YOUR BREAST? YES NO IF YES, WHICH SIDE? LEFT RIGHT

DO YOU HAVE ANY DISCHARGE FROM YOUR NIPPLES? YES NO IF YES, WHICH SIDE? LEFT RIGHT

DO YOU HAVE ANY DISCOMFORT/PAIN IN YOUR BREAST? YES NO IF YES, WHICH SIDE? LEFT RIGHT

DO YOU HAVE ANY IMPLANTS? YES NO

HAVE YOU HAD BREAST CANCER IN THE LAST 2 YEARS? YES NO IF YES, WHICH SIDE? LEFT RIGHT YEAR _____

IF YES TO ANY OF THE QUESTIONS ABOVE THE PATIENT IS NOT ELIGIBLE FOR SCREENING MAMMOGRAMS. PLEASE REFER TO THE ROSE FOR DIAGNOSTIC SERVICES.

HAVE YOU HAD ANY OTHER FORM OF CANCER? YES NO IF YES, TYPE: _____

HAVE YOU HAD PREVIOUS BREAST SURGERY? YES NO IF YES, WHICH SIDE? LEFT RIGHT

RESULT: _____
 (BIOPSY, BENIGN CYST, IMPLANT, MASTECTOMY)

HAVE YOU HAD A HYSTERECTOMY? YES NO IF NO, YEAR OF SURGERY? _____

DO YOU STILL HAVE YOUR OVARIES? YES NO IF NO, YEAR OF SURGERY? _____

DO YOU HAVE CHILDREN? YES NO IF YES, LIST THEIR AGES: _____

DID YOU BREAST FEED? YES NO HOW MANY CHILDREN BREAST FED? _____

AGE OF FIRST MENSTRUAL PERIOD: _____ YOUR AGE AT FIRST FULL TERM PREGNANCY: _____ AGE OF MENOPAUSE: _____

DO YOU TAKE HORMONES? YES NO IF YES, TYPE(S): _____

HAVE YOU EVER TAKEN HORMONES? YES NO HOW LONG HAVE YOU TAKEN THEM _____ TOTAL YEARS IN LIFETIME _____

DO YOU (OR HAVE YOU EVER) TAKE BIRTH CONTROL PILLS? YES NO IF YES, HOW LONG? _____

WHEN LAST TAKEN IF NOT ON THEM NOW? _____

HAVE YOU EVER SMOKED? YES NO IF YES, HOW LONG? _____

DO YOU HAVE ANY FAMILY HISTORY OF BREAST CANCER? YES NO IF YES, WHO AND AT WHAT AGE? _____

MOTHER _____ AGE _____ DAUGHTER _____ AGE _____

AUNT _____ AGE _____ SISTER _____ AGE _____

GRANDMOTHER _____ AGE _____ OTHER _____ AGE _____

DO YOU EXAMINE YOUR BREASTS MONTHLY? YES NO SOMETIMES

IS THIS YOUR FIRST (BASELINE) MAMMOGRAM? YES NO

IF NO, HAVE YOU EVER SEEN AT THE ROSE YES NO YEAR _____

IF NOT, WHERE WAS YOUR LAST MAMMOGRAM _____ YEAR _____

DID YOU HAVE THE SAME LAST NAME: YES NO IF NO, WHAT WAS THE NAME: _____

THE ROSE FINANCIAL ASSISTANCE APPLICATION

Date: _____ Representative: _____ New/Annual/Follow-up Permanent Legal Resident: Y N Date Entered: _____
Date Entered/Trip Resident

How did you hear about the program: _____ Medical Insurance: Y N Medicaid Gold Card Medicare Other _____

Internal PID _____ Elsewhere PID _____ County _____

Last Name _____ First Name _____ MI _____ Address _____ Suite/Tri/Apt/PO Box _____ City _____ State _____ Zip Code _____

Sex _____ DOB _____ Age _____ Ethnicity _____ Primary Language _____ Social Security No. _____ Home Phone _____

Business Phone _____ Cell/Mobile _____ Alternate Contact _____ Alternate Phone _____ Relationship _____

E-Mail Address _____ Patient Status _____ Barriers (Cultural, Psychological, Financial, Physical and/or other) _____

Y N _____ S M D W _____ Marital Status _____ Total Monthly Income _____ No. of Deps (under age 18 or 24 if in school) _____
 Head of Household _____

Dep 1 (DOB) _____ Dep 2 (DOB) _____ Dep 3 (DOB) _____ Dep 4 (DOB) _____ Dep 5 (DOB) _____

Y N _____ Private Deductible Amount _____ Y N _____ Referral/Order Height _____ Weight _____
 Proof of Income _____

Y N _____ Date of Implant Sur. _____ Pregnant? _____ Age at First Birth _____ Breast Feeding _____ Y N _____
 Implants (if so Type) _____ Number of Births _____

Referring Physician _____ Address _____ Phone No. _____ Fax No. _____

Y N _____ Menopausal _____ Post Menopausal _____ Y N _____

Y N _____ Last Period _____ Age at First Period _____ Y N _____

Y N _____ Date if Yes _____ Facility Site _____ Problems or Pain _____ Y N _____ Date if Yes _____ Description _____
 Previous mammogram _____

Y N _____ Date if Yes _____ Location _____ Y N _____ Date if Yes _____ DX Location _____
 Abnormal Results _____

Y N _____ Date if Yes _____ Prev Cancurs _____ Date if Yes _____ Family Hx _____ Who? (Relationship) _____
 Prev Breast Cancer _____

Y N _____ Date if Yes _____ Date if Yes _____
 certify that the foregoing information is true and correct to best of my knowledge, and I understand that any misrepresentation or
 willful omission of facts shall be cause for rejection of this application.

herby voluntarily consent to coordination of services to accomplish care and treatment. I acknowledge that no guarantees have been
 made as to the results of treatments or examinations. I hereby authorize my insurance benefits to be paid directly to The Rose, realizing I
 am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient Signature _____ Date _____

Physician Used: _____

Reviewed for TX Act: _____ By: _____

Unit: _____ Locale _____

Special Consideration: _____

Special Consideration: _____

Special Consideration: _____

Physician Used: _____

Special Consideration: _____

Special Consideration: _____

Additional Procedures: _____
 Dx Mammogram _____ Ultrasound _____ Biopsy _____ Y/N/C _____
 Date: _____ Time: _____ Center: _____



A non-profit breast cancer organization

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
MEDICAL RECORDS RELEASE FOR THE ROSE

By signing this authorization, I authorize The Rose to:

- Use and/or disclose certain protected health information (PHI) about me for the purposes of health care operations. This may include business management activities, general administrative functions and clinical management, such as to obtain a referral, quality assurance, quality improvement, case management, training programs, licensing, credentialing, certification, accreditation, compliance programs, research, fundraising and marketing activities that support the Rose and ensure that quality care is delivered.
- Obtain all of my previous mammogram/ultrasound films and their corresponding reports to be released for comparison studies. Previous films and reports are required for comparison to be provided to The Rose 12700 N. Featherwood, #260, Houston, TX 77034 281-484-4708.

Patient Name: _____ Date of Birth _____
 Name of Facility & Year of previous mammogram: _____

- Obtain any reports involving additional testing based on recommendations by the interpreting radiologist. I hereby voluntarily consent to coordination of services to accomplish care and treatment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of my information. This authorization will expire one year from the date signed below. The Rose will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

HIPAA does not require you to sign this authorization in order to receive treatment from The Rose. However, it is the policy of The Rose that every patient is required to provide the name of their referring physician of record to receive a copy of their report and therefore authorizing The Rose to release medical records.

I have the right to refuse to sign this authorization for the specific reasons stated here and to whom the limits apply, other than the release of medical records: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Rose Privacy Officer at: 12700 N. Featherwood, #260, Houston, TX 77034 281-484-4708, fax 281-484-5626. Please forward previous films and reports to the same address Attn: Medical Records.

Signed by: _____ If Legal Guardian -Relationship to Patient _____
 Signature of Patient or Legal Guardian _____
 Print Patient's Name _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have been given the opportunity to read The Rose's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Name of Patient or Personal Representative _____ Signature of Patient or Personal Representative _____
 Date _____ FOR OFFICE USE ONLY _____
 _____ Refused to sign _____
 _____ Witnessed _____

PATIENT INFORMATION & INSURANCE FORM



PATIENT ID # _____

NAME: _____ (Last) _____ (First) _____ (Middle Initial) _____

STREET MAILING ADDRESS _____ **APT #** _____

CITY, STATE, ZIP CODE _____

HOME NUMBER _____ **CELL NUMBER** _____ **EMAIL:** _____

AGE _____ **DATE OF BIRTH** _____ **S.S.#** _____ **MARITAL STATUS** _____ **SEX** _____

ETHNIC ORIGIN: White Hispanic A.A./Black Asian American Indian Hawaiian/Pacific Islander Other

YOUR DOCTOR (S) or CLINIC(S) _____ (Last Name) _____ (First Name)

Doctor or Clinic Street Address, City, State, Zip Telephone and Fax Number

EMPLOYER _____ **WORK TELEPHONE** _____

SPOUSE OR PARENT INFORMATION

NAME _____ **HOME TELEPHONE** _____

ADDRESS _____

EMPLOYER _____ **PHONE#** _____ **OCCUPATION** _____

SOCIAL SECURITY# _____ **DATE OF BIRTH** _____ **RELATIONSHIP** _____

EMERGENCY INFORMATION - friend, relative, or neighbor we may contact in unable to reach the above

NAME _____ **ADDRESS** _____

HOME TELEPHONE# _____ **WORK#** _____ **RELATIONSHIP** _____

We provide a sponsorship program for women meeting the high-risk, low income criteria. If you feel that you qualify for financial assistance through this program, please check here: _____

INSURANCE INFORMATION—(I understand, realize that all medical and surgical charges incurred are my responsibility. Should the account become delinquent, the entire amount will be due and payable.)

PRIMARY INSURANCE

INS. NAME _____ **INS. NAME** _____

INS. ADDRESS _____ **INS. ADDRESS** _____

INS. PHONE# _____ **INS. PHONE#** _____

POLICY# _____ **GROUP#** _____ **POLICY#** _____ **GROUP#** _____

INSURED'S NAME _____ **INSURED'S NAME** _____

INSURED'S DATE OF BIRTH _____ **INSURED'S DATE OF BIRTH** _____

SECONDARY INSURANCE

INS. NAME _____

INS. ADDRESS _____

INS. PHONE# _____

POLICY# _____ **GROUP#** _____

INSURED'S NAME _____

INSURED'S DATE OF BIRTH _____

I hereby voluntarily consent to coordination of services to accomplish care and treatment. I acknowledge that no guarantees have been made as to the results of treatments or examination. I hereby authorize my insurance benefits to be paid directly to The Rose, realizing I am responsible to pay non-covered services and I here by authorize the release of pertinent medical information to insurance carriers.

DATE _____

Patient Signature _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company

The Rose all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Rose may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Guardian or Personal Representative Date

Please print Name of Patient, Guardian or Personal Representative Relationship to Patient