Mammos On the Move at DESERT IMAGING

On the day of your appointment, please provide:

- Insurance Card
- Driver's License or other valid form of identificaion
- Doctor's order IF YOU ARE UNDER 40 YEARS OF AGE OR YOUR DOCTOR IS ON THE LIST OF PHYSICIANS THAT REQUIRE ORDER'S ON THE LIST PROVIDED WITH THE EVENT COORDINATOR

PATIENT INFORMATION

Patient #:	Gender:	Date of Birth:
Last Name:		Age:
First Name:	Middle Initial:	Social Security #:
Address:		Home Phone:
City, State, Zip:		
Name and Phone Number of Emergency Contact:		
Email:		Cellular/Mobile Phone:

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 assigh 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 _____ **Date** _____

ACKNOWLEDGEMENT 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.

Signature _____ **Date** _____

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

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Circle one or more desired method of communication:

Telephone ***Cell Phone*** ***Text/SMS*** ***Email*** ***Other***

"By signing below the patient hereby grants Desert Imaging/M.O.M. permission to be contacted by any or all method(s) selected by signee."

_____ _____

Patient Signature *Date*

Please do not wear any deodorant or talcum powder & we suggest you wear a two piece outfit the day of the appointment

Medical History

Patient Account # _____

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? _____ When? _____
Age of last menstrual period? _____ Age when started menstrual cycle? _____
Number of pregnancies you have had? _____ Have you undergone menopause? _____
Ovaries been removed? _____ If yes, when? _____ Do you take hormones? _____
Name of hormone supplements(s) _____ Taken for how long? _____

Patient Signature _____

Procedures: **Tech Signature** _____

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 Symptons: (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 _____