File No	Date	Appt. Time	Accession #	Computer #

Last Name	First	Middle	Area Code Primary Phone

Address (Appt#)	City	State	Zip Code	Social Security #
			-	

Age	Race	You Chose Us because	Physician	Date of Birth

Patient's Employer	Phone	Cell Phone	Insurance Company Name

1) Please circle history of breast cancer: None Self Mother Sister Daughter Grandmother Aunt Father Brother

2) Please circle history of ovarian cancer: None Self Mother Sister Daughter Grandmother Aunt

3) How many children have you given birth? ____How old were you when your 1st child was born? 19
Are you 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? Yes No If so, which breast, what year and what type _____

7) Do you have breast implants? Yes No If so, date of surgery _____

8) When was your last physical breast exam by a doctor? _____ Dr. _____

9) When and where was your last mammogram? _____

10) May we use your email address? Yes No If Yes, provide _____

OFFICE USE ONLY (Please do NOT print below this line.) (Screening)

Breast pain _____

Breast lumps _____

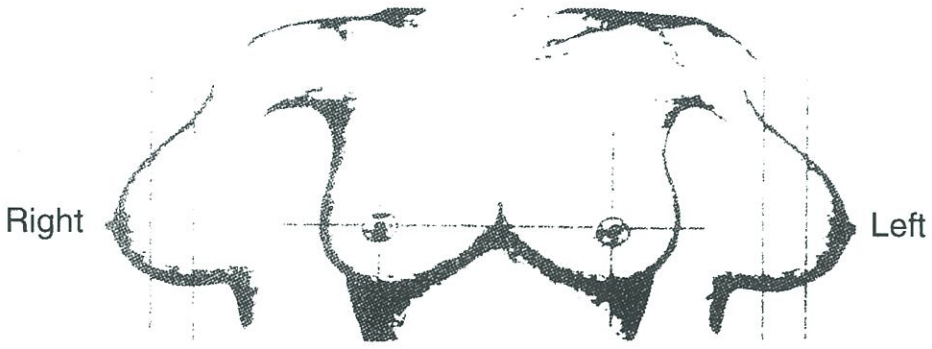
Nipple discharge _____

MRI (prev) _____

Screen Diagnostic

PAD GKY RGF

☐ Consult



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

	Full	FS	Mag	Lat	Xccl	Othr	
L							L
R							R

Consultation
1 2 3 4

Tomosynthesis _____

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-RAYS 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 THE 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.

_____ Date _____
Patient or Guardian Signature

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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize OKLAHOMA BREAST CARE CENTER to release information contained in my medical record including information regarding scheduled appointments, medications and/or billing on my account to the following individuals.:

Name: _____
Relationship

Name: _____
Relationship

Name: _____
Relationship

_____ Date _____
Patient or Guardian Signature