



METHODIST RICHARDSON MEDICAL CENTER 循道李察遜醫療中心  
免費乳房 X 光檢查 (經濟援助) 申請表格

填表須知 Instructions:

基於對社區服務承諾，並取得達拉斯和北德州高素珊乳癌基金會的援助，循道李察遜醫療中心的婦女保健中心對符合條件，經濟上有困難或沒有醫療保險的人，提供經濟補助。As part of the grant funded by the Dallas County and North Texas Affiliates of the Susan G. Komen for the Cure, and our commitment to serve the community, Methodist Richardson Medical Center, Center for Women's Health elects to provide financial assistance to individuals who are financially indigent or medically indigent and satisfy certain requirements.

我們需要你的資料，以便決定申請者是否符合補助資格。敬請填妥申請表每一個項目，把表格交回報名處，或寄回下列地址。To determine if a person qualifies for a free mammogram screening, we need to obtain certain information as outlined within this application. Please complete the application in full and return the completed form to the Registration Representative or mail completed form to the following address:

Methodist Richardson Medical Center  
403 W. Campbell Rd, Suite 205  
Richardson, TX 75080  
Attn: Center for Women's Health/ABHOP

通過審核的受檢者，我們中心將通知 X 光檢驗時間。如有任何疑問，請與中心聯絡，洽詢電話：(972) 498-8601  
Upon receipt, verification, and approval of this application, you will be notified of your appointment time.  
If you have questions, please call (972) 498-8601.

請用英文填寫以下問題 Please answer the following questions in English:

申請人姓氏 Last Name \_\_\_\_\_ 申請人名字 First Name \_\_\_\_\_

你的國籍 Nationality \_\_\_\_\_ 最常使用的語言 Primary language spoken \_\_\_\_\_

家中有多少人 Total number of people living in your household \_\_\_\_\_

全家總收入 Total household income \_\_\_\_\_

每週  
per week

每月  
per month

每年  
per year

你是否永久居民  是 Yes  否 No  
Are you a permanent resident?

(申請者必須居住在德州達拉斯郡、科林郡或丹頓郡)  
(Must live in Dallas, Collin, or Denton County)

你有買健康保險嗎?  有 Yes  沒有 No  
Do you have Health Insurance?

如有保險卡，請打印卡的前面和後面跟申請表格一併寄回中心  
If yes, please mail a copy of card (front and back) with this application form

你有沒有 Medicare/Part B? Do you have Medicare/Part B?  有 Yes  沒有 No

你有沒有 Medicaid? Do you have Medicaid?  有 Yes  沒有 No

凡符合以下申請條件者，方可申請免費乳房 X 光檢查：

- 居住在德州達拉斯郡 Dallas County、科林郡 Collin County 或丹頓郡 Denton County
- 年齡四十歲或以上之婦女
- 申請時乳房內沒有硬塊、腫瘤，或乳房不正常者
- 乳房曾病患者，必須符合以下條件：
  - 良性切片檢查一年或以上
  - 完成乳癌手術和治療兩年或以上，獲醫生批准接受定期乳房 X 光篩檢



**METHODIST RICHARDSON MEDICAL CENTER**  
403 West Campbell Rd. Suite #205 Richardson, TX 75080  
Tel: (972) 498-8601 Fax: (972)-498-8634

**P A T I E N T P R E - R E G I S T R A T I O N F O R M**

**申請者必須以英文填寫登記表格 (Fill in English)**

**申請人資料: Applicant's information**

申請人姓氏 LAST NAME \_\_\_\_\_ 申請人名字 FIRST NAME \_\_\_\_\_ 年齡 AGE \_\_\_\_\_

出生日期 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 婚姻狀況 \_\_\_\_\_ 出生地 \_\_\_\_\_ 族裔 \_\_\_\_\_  
DATE OF BIRTH (月 MONTH/日 DAY/年 YEAR) MARITAL STATUS BIRTHPLACE RACE

家居地址 HOME ADDRESS \_\_\_\_\_ 公寓號碼 APARTMENT NUMBER \_\_\_\_\_

城市 CITY \_\_\_\_\_ 州 STATE \_\_\_\_\_ 郵區號碼 ZIP \_\_\_\_\_

家居電話 HOMEPHONE(\_\_\_\_) \_\_\_\_\_ 手機 CELLPHONE (\_\_\_\_) \_\_\_\_\_ 工作電話 WORKPHONE (\_\_\_\_) \_\_\_\_\_

公司名字 EMPLOYER'S NAME \_\_\_\_\_

公司地址 ADDRESS \_\_\_\_\_ 城市 CITY \_\_\_\_\_ 州 STATE \_\_\_\_\_ 郵區號碼 ZIP \_\_\_\_\_

社安號碼 SOCIAL SECURITY NUMBER \_\_\_\_\_ 職業 OCCUPATION \_\_\_\_\_

**配偶資料: Spouse Information**

配偶名字 SPOUSE NAME \_\_\_\_\_ 配偶社安號碼 SOCIAL SECURITY NUMBER \_\_\_\_\_

配偶出生日期 DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 配偶職業 OCCUPATION \_\_\_\_\_  
(月 MONTH/日 DAY/年 YEAR)

配偶公司名字 EMPLOYER'S NAME \_\_\_\_\_ 配偶工作電話 WORKPHONE (\_\_\_\_) \_\_\_\_\_

配偶公司地址 ADDRESS \_\_\_\_\_

**緊急時通知誰人? IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_ 和你的關係 RELATIONSHIP \_\_\_\_\_**

地址 ADDRESS \_\_\_\_\_ 手機/聯絡電話 CELL PHONE/CONTACT NUMBER (\_\_\_\_) \_\_\_\_\_

你主要看地醫生 PRIMARY CARE PHYSICIAN \_\_\_\_\_ 電話 PHONE (\_\_\_\_) \_\_\_\_\_

地址 ADDRESS \_\_\_\_\_

你的檢驗報告可以讓誰人知道? 請在下面列出其姓名和電話, 此人必須能代表你使用英語跟醫生交談。  
Please list all persons and home numbers whom you would like us to share your results with. Please make sure at least one of them can speak English on your behalf.

- 配偶 SPOUSE       子女 CHILDREN       親人例如 (兄弟姊妹) OTHER FAMILY MEMBER (BROTHER, SISTER, AUNT, UNCLE)  
 其他 (例如朋友) OTHER (FRIEND) \_\_\_\_\_ 電話 PHONE (\_\_\_\_) \_\_\_\_\_

我明白循道李察遜醫療中心可以查實我在申請表上填寫有關本人的經濟資料, 用以衡量這份表格。在此我授權循道李察遜醫療中心可接觸本人的僱主來證實以上的資料, 同時可向信用徵詢公司索取報告。我明白這份資料是用來決定我是否符合經濟援助的資格, 同時醫療中心可以隨時向有關方面索取新的資料。我明白及同意在這份表格上若有任何錯誤或虛假的資料, 我的經濟援助申請將被取消。

I understand Methodist Richardson Medical Center may verify the financial information contained in this application in connection with Hospital's evaluation of this application, and hereby authorize the hospital to contact my employer to certify the information provided and request reports from credit reporting agencies. I am aware that this information is used to determine my eligibility for financial assistance and that the hospital may contact these sources to update this information at any time. I am aware that the falsification of information on this Application will result in denial of financial assistance.

申請人或有關人事簽署 Patient (or Responsible Party) Signature \_\_\_\_\_ 日期 Date \_\_\_\_\_

METHODIST RICHARDSON MEDICAL CENTER

403 WEST CAMPBELL RD  
SUITE 205  
RICHARDSON, TX  
(972) 498-8600

乳房 X 光檢查病人問卷 MAMMOGRAPHY PATIENT QUESTIONNAIRE

所有資料保密，請選擇『是』或『否』和回答所有問題  
All replies are confidential. Please circle YES or NO and answer ALL questions.

日期 TODAY'S DATE:

PATIENT IDENTIFIER NUMBER:

姓氏 LAST NAME	名字 FIRST NAME	生日 DATE OF BIRTH	年齡 YOUR AGE
你常用的地址,包括城市,州和郵區號碼 ADDRESS (Please list an address where mail will <u>always</u> reach you) CITY, STATE, ZIP			
你常用的電話號碼 PHONE: (Please list a number where the doctor can <u>always</u> reach you)			
家居電話 Home:	手電 Cell:	工作電話 Work:	
你主要看的醫生 PRIMARY REFERRING PHYSICIAN:	電話 PHONE:	你其他看的醫生 2 <sup>ND</sup> REFERRING PHYSICIAN:	電話 PHONE:

選擇 Circle one

是 YES 否 NO 你是否曾做過乳房 X 光檢查或乳房超聲波掃描? 何年何月做? 在那里做? 什麼診所?  
Have you had a **mammogram** or **breast ultrasound** before? If **YES**, when (approximate date)? **Where** and at **which** facility:

是否還有舊 X 光片記錄? Are your **films** still there? 有 YES 沒有 NO 最近一次被醫生檢查乳房是何年何月?  
Last breast exam by physician was

是 YES 否 NO 上次乳房 X 光檢查後, 你的乳房是否發現新腫塊? 假如有, 在何年何月發現? 在哪邊乳房? 右邊 左邊 兩邊都有  
Since your last mammogram, are there any **new lumps** in your breasts? If **YES** when was it first noted: If **YES**, in which breast: Right Left Both

你的醫生是否知道你有腫塊嗎? Is your physician aware of the lump(s)? 是 YES 否 NO

是 YES 否 NO 你的乳房是否感到不舒適、疼痛或酸痛? 在哪邊乳房: 右邊 左邊 兩邊都有  
Any **discomfort, pain or soreness**? If **YES**, in which breasts: Right Left Both

這是否新出現的問題? Is this a new problem? 是 YES 否 NO 這問題已經維持多久? How long have you had this pain?

是 YES 否 NO 你的乳頭是否內陷或縮陷? 在哪邊乳房: 右邊 左邊 兩邊都有 你的乳頭是否長期內陷或縮陷? 是  
Is either nipple **retracted/ inverted**? If **YES**, in which breast: Right Left Both Has it always been retracted? YES NO

乳頭有沒有乾痛? 在哪邊乳房? Any crusting sores at the nipple(s)? 右邊 Right 左邊 Left 兩邊都有 Both

是 YES 否 NO 乳頭是否有分泌物? 在哪邊乳房? 右邊 左邊 兩邊都有  
Any **discharge** from the nipples? If **YES**, in which breast: Right Left Both

你的乳頭是否長期有分泌物? 是 否 你是否在衣服上看到? 是 否 分泌物中是否有血? 有 沒有  
Have you always had this discharge? YES NO Do you see it in your clothing? YES NO Has the discharge ever been bloody? YES NO

是 YES 否 NO 你是否有乳癌病歷? 在哪邊乳房? 右邊 左邊 兩邊都有 何年何月被診斷患乳癌?  
Have you had a breast cancer? If **YES**, in which breast? Right Left Both What year was CA diagnosed

你會否接受輻射治療? 是 否 整個乳房切除手術? 是 否 何年何月完成治療?  
Did you have Radiation? YES NO Mastectomy? YES NO When did you complete treatment?

是 YES 否 NO 你會否做過乳房手術、切片檢查或針吸活檢? 何年何月做: 在哪邊乳房? 右邊 左邊 兩邊都有  
Have you had previous breast surgery, **biopsy** or a needle aspiration? Approximate date (s): If **YES**, in which breast: Right Left Both

你有什麼癥兆或症狀? What symptoms do you have?

是 YES 否 NO 你是否有隆乳或做過乳房整形手術? Do you have breast **implants** now or have you had any augmentations in the past? 何年何月做? When?

是 YES 否 NO 你的親屬是否有乳房病患者? 她們是否在經絕前罹患乳癌? 是 否 (在什麼年齡病發?)  
Any **family history** of breast cancer? Did it occur before menopause? YES NO (or about what age?)

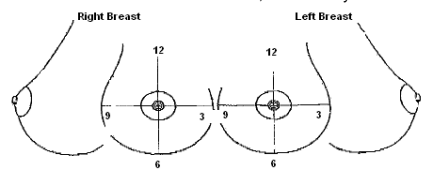
什麼親戚罹患乳癌? In which relative(s)? 母親 Mother 姐妹 Sister 女兒 Daughter 其他 Other

是 YES 否 NO 你是否服用激素或賀爾蒙? 請選擇其中藥物: Premarin, Provera, PremPro, Prometrium, 或 or birth-control pills 避孕丸?  
Do you take female **hormones**? (Please circle) Premarin, Provera, PremPro, Prometrium, or birth-control pills?

如有服用, 服用了多久? 最近是否增加或減少劑量? 增加 減少  
If **YES**, for how long? Recent **increase** or **decrease** (please circle) in the dosage? increase decrease

是 YES 否 NO 你現在是否懷孕? Are you **pregnant** at this time?

你至今懷孕多少次? Number of Pregnancies? \_\_\_\_\_  
你第一次懷孕的年齡? At what age was your first pregnancy? \_\_\_\_\_  
TECHNOLOGIST: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_



我授權循道李察遜醫院婦女保健中心索取我過往乳房 X 光檢查照片、結果和病歷報告。 I AUTHORIZE THE RELEASE OF MY PREVIOUS MAMMOGRAM FILMS AND OTHER REPORTS (INCLUDING PATHOLOGY REPORTS) TO METHODIST RICHARDSON MEDICAL CENTER/ CENTER FOR WOMEN'S HEALTH.

病人簽名或授權代表人簽名 SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

日期 DATE