



METHODIST RICHARDSON MEDICAL CENTER

Instructions:

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.

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/Asian Grant

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.

Please answer the following questions in English:

Last Name _____ First Name _____

Nationality _____ Primary language spoken _____

Total number of people living in your household _____

Total household income _____

per week per month per year

Are you a permanent resident? Yes No (Must live in Dallas, Collin, or Denton County)

Do you have Health Insurance? Yes No If yes, please mail a copy of card (front and back) with this application form

Do you have Medicare/Part B? Yes No

Do you have Medicaid? Yes No

The following criteria must be met in order to qualify for a free mammogram screening:

- Reside in Dallas County, Collin County, or Denton County
- Female of Asian descent
- Be 40 years or older
- Have no implants
- Feel no lumps, bumps, or abnormality in breasts
- Individuals with a previous history of breast problems must meet the following criteria:
 - Must be 1 year post benign breast biopsy
 - Must be at least 2 years post lumpectomy for carcinoma & finish treatment or discharged for annual screening



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

(Complete in English)

Applicant's information

LAST NAME _____ FIRST NAME _____ AGE _____

DATE OF BIRTH ____/____/____ (MONTH/ DAY/ YEAR) MARITAL STATUS _____ BIRTHPLACE _____ RACE _____

HOME ADDRESS _____ APARTMENT NUMBER _____

CITY _____ STATE _____ ZIP _____

HOMEPHONE (____) _____ CELLPHONE (____) _____ WORKPHONE (____) _____

EMPLOYER'S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ OCCUPATION _____

Spouse Information

SPOUSE NAME _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH ____/____/____ (MONTH/ DAY/ YEAR) OCCUPATION _____

EMPLOYER'S NAME _____ WORKPHONE (____) _____

ADDRESS _____

IN CASE OF EMERGENCY NOTIFY _____ RELATIONSHIP _____

ADDRESS _____ CELL PHONE/CONTACT NUMBER (____) _____

PRIMARY CARE PHYSICIAN _____ PHONE (____) _____

ADDRESS _____

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.

SPOUSE CHILDREN OTHER FAMILY MEMBER (BROTHER, SISTER, AUNT, UNCLE)

OTHER (FRIEND) _____ PHONE (____) _____

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.

Patient (or Responsible Party) Signature _____ Date _____

METHODIST RICHARDSON MEDICAL CENTER

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

MAMMOGRAPHY PATIENT QUESTIONNAIRE

All replies are confidential. Please circle YES or NO and answer ALL questions.

TODAY'S DATE:

PATIENT IDENTIFIER NUMBER:

LAST NAME	FIRST NAME	DATE OF BIRTH	YOUR AGE
ADDRESS: (Please list an address where mail will <u>always</u> reach you) CITY, STATE, ZIP			
PHONE: (Please list a number where the doctor can <u>always</u> reach you)			
Home:	Cell:	Work:	
PRIMARY REFERRING PHYSICIAN:	PHONE:	2 ND REFERRING PHYSICIAN	PHONE:

CIRCLE ONE

Have you had a **mammogram** or **breast ultrasound** before? If **YES**, when (approximate date)?
YES **NO** **Where** and at **which** facility: _____ Are your **films** still there? **YES** **NO**
 Last breast exam by physician was _____

Since your last mammogram, are there any **new lumps** in your breasts? If **YES** when was it first noted: _____
YES **NO** If **YES**, in which breast: Right Left Both. Is your physician aware of the lump(s)? **YES** **NO**

Any **discomfort, pain or soreness**? If **YES**, in which breasts: Right Left Both
YES **NO** Is this a new problem? **YES** **NO** How long have you had this pain?

Is either nipple **retracted/ inverted**? If **YES**, in which breast: Right Left Both
YES **NO** Has it always been retracted? **YES** **NO** Any crusting sores at the nipple(s)? Right Left Both

Any **discharge** from the nipples? If **YES**, in which breast: Right Left Both
YES **NO** 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**

Have you had a **breast cancer**? If **YES**, in which breast? Right Left Both What year was CA diagnosed _____
YES **NO** Did you have Radiation? Mastectomy? When did you complete treatment?

Have you had previous breast surgery, **biopsy** or a needle aspiration? Approximate date (s): _____
YES **NO** If **YES**, in which breast: Right Left Both What symptoms do you have?

Do you have breast **implants** now or have you had any augmentations in the past? When?

Any **family history** of breast **cancer**? Did it occur before menopause? **YES** **NO** (or about what age? _____
YES **NO** In which relative(s)? Mother Sister Daughter Other _____

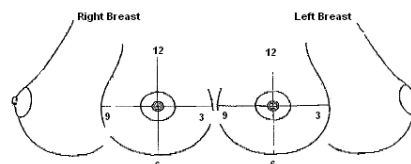
Do you take female **hormones**? (Please circle) Premarin, Provera, PremPro, Prometrium, or birth-control pills?
YES **NO** If **YES**, for how long? _____ Recent **increase** or **decrease** (please circle) in the dosage?

Are you **pregnant** at this time? _____

Number of Pregnancies? _____ Did you breast feed any of your children for longer than one month? **YES** **NO**
 At what age was your first pregnancy? _____ Do you still have **menstrual** periods? **NO** If **YES**, when was your last one? _____

TECHNOLOGIST: _____

COMMENTS: _____



I AUTHORIZE THE RELEASE OF MY PREVIOUS MAMMOGRAM FILMS AND OTHER REPORTS (INCLUDING PATHOLOGY REPORTS) METHODIST RICHARDSON MEDICAL CENTER/ CENTER FOR WOMEN'S HEALTH.

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

DATE