English

Asian Breast Health Outreach project

METHODIST RICHARDSON MEDICAL CENTER

Instructions:

As part of the grants funding provided 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
2831 E. President George Bush Turnpike
Richardson, TX 75082
Attn: Women's Imaging/Asian Grant

Upon receipt, verification, and approval of this application, you will be notified of your appointment time.
If you have questions, please call (469) 204-6888. Fax: (469) 204-6886.

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 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 Collin or Denton County
- Female of Asian descent
- Be 40 years or older
- 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

METHODIST RICHARDSON Women's Imaging
2831 E. President George Bush Turnpike, Richardson, TX 75082
Tel: (469) 204-6888 Fax: (469) 204-6886

PATIENT PRE-REGISTRATION FORM

(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 _____/_____/_____ OCCUPATION _____
(MONTH/ DAY/ YEAR)

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

2831 E. President George Bush Turnpike
Richardson, TX 75082
Fax: (469) 204-6886

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 always reach you) CITY, STATE, ZIP

PHONE: (Please list a number where the doctor can always reach you)

Home: **Cell:** **Work:**

PRIMARY REFERRING PHYSICIAN:	PHONE:	2ND REFERRING PHYSICIAN	PHONE:

CIRCLE ONE

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

YES NO 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. Is your physician aware of the lump(s)? YES NO

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

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Has it always been retracted?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

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

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

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

YES NO Do you have breast **implants** now or have you had any augmentations in the past? When?

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

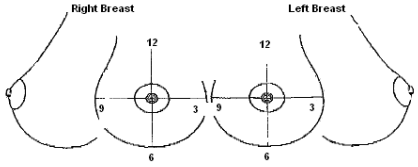
YES NO Do you take female **hormones?** (Please circle) Premarin, Provera, PremPro, Prometrium, or birth-control pills?
If **YES,** for how long? _____ Recent **increase** or **decrease** (please circle) in the dosage?

YES NO 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