5 Severance Circle • Cleveland Heights, OH 44118
(216) 382-8874 • (216) 382-7166 Fax
wdc-mammogram.com

PATIENT INFORMATION FORM

PLEASE PRINT

Name: _____ **SSN:** XXX-_____ - _____ DoB: _____

Home Address: _____

(Street) (Apt)

_____

(City) (State) (Zip)

Home Phone: _____ **Cell Phone:** _____

_____

Your Doctor's Full Name: _____

Doctor's Address: _____

(Street) (Suite) (City) (Zip)

Doctor's Phone #: _____

I also verify that I am a current patient of Dr._____ **and that I have been seen/treated by this Doctor within the last 12 months.**_____**(initial)**

My medical insurance is with:_____

ID# or Cert# _____ Group # _____

I have secondary insurance: Yes or No – please circle one

Secondary insurance is with: _____

ID# or Cert# _____ Group # _____

I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices. _____(Initial here)

I authorize the release of any medical information to process this claim. I authorize payment of medical benefits to Women's Diagnostic Center by Innovacare, LLC for medical services provided. I understand I am responsible for any balance not paid by my insurance carrier(s).

Signature: _____ Date: _____

I acknowledge that my refusal to sign this form or provide requested information will result in the inability of Women's Diagnostic Center by Innovacare, LLC to provide mammography services and I hold them harmless from any liability that occurs as the result of my refusing to comply with the policies of the organization. _____ (initial here)

Signature: _____ Date: _____

MEDICAL HISTORY FOR BREAST DIAGNOSTIC EXAMINATION

Name _____ Date _____

SS# XXX- _____ - _____Your Doctor's Full Name: _____

Date of Birth: _____ Have you had a previous mammogram? Yes____ No____

Have you had a hysterectomy? Yes____ No____

Have you ever taken birth control pills or hormone replacement? Yes____ No____

Has anyone in your family had breast cancer? Yes____ No____ What relationship to you?_____

_____

Please answer the following questions about your breasts:

	NO	RIGHT	LEFT
Lumps in breast	❑	❑	❑
Discomfort, pain, soreness	❑	❑	❑
Discharge from nipple	❑	❑	❑
Previous breast surgery	❑	❑	❑
Biopsy	❑	❑	❑
Mastectomy	❑	❑	❑
Moles	❑	❑	❑
Do you have breast implants?	❑	❑	❑

Notes:_____

_____

_____