Methodist Healthcare

LABEL

Mobile Mammography Unit Registration Form

*Please fax the completed form to **901-266-6643** to complete your registration.*

Please answer the following questions regarding your screening mammogram:

1. Do you have any NEW breast symptoms such as a lump, nipple discharge, skin thickening or focal area of pain in one or both breasts? ☐ Yes ☐ No
2. Have you ever had breast cancer? ☐ Yes ☐ No
   If so, when? _____
3. Are you pregnant or breastfeeding? ☐ Yes ☐ No
4. Are you here for a follow-up from an abnormality found on a mammogram done elsewhere? ☐ Yes ☐ No
5. Have you had a mammogram in the past 12 months? ☐ Yes ☐ No

*** If you have answered **YES** to any of the questions above, you are **NOT** eligible for a screening mammogram. Please contact your physician to schedule a diagnostic mammogram with any of the Methodist Breast Centers at 901-516-9000.

Personal Information:

Name: _____ _____ _____
Last First M.I.

Address:_____

City:_____ State: _____ ZIP: _____

DOB:_____ SSN: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Race : _____ Ethnicity: Hispanic/Latino: ☐Yes ☐No Language: _____

Email Address: _____

Physician Information:

Primary Care Physician: _____ _____
Last First

OB/GYN: _____ _____
Last First

Has your name changed since your last visit to either physician? _____

Do you have breast implants? ☐ Yes ☐ No

Is this your first mammogram? ☐ Yes ☐ No

Place and date of most recent mammogram:

_____ _____
Place Date

Methodist Healthcare

LABEL

Employment Information:

☐ FT ☐ PT ☐ Unemployed ☐ Disabled ☐ Retired (Retirement Date) _____

Employer Name _____

Address.: _____

City:_____ State: _____ ZIP: _____

Insurance Information:

Do you have Health Insurance? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No (If **yes**, then complete MSP form attached)

Primary Insurance:

Name of Ins Plan: _____

Subscriber Name: _____ _____ _____
Last First M.I.

Subscriber Relation to Pt_____ Gender_____ DOB:_____

SSN#_____ Policy ID Number: _____

Group Name #:_____Group #_____

Eligibility/Benefits Phone Number #: _____

Claims Address: _____

Secondary Insurance:

Name of Ins Plan: _____

Subscriber Name: _____ _____ _____
Last First M.I.

Subscriber Relation to Pt_____ Gender_____ DOB:_____

SSN#_____ Policy ID Number: _____

Group Name #:_____Group #_____

Eligibility/Benefits Phone Number #: _____

Claims Address: _____

Methodist Healthcare

LABEL

Medicare Secondary Payer Questionnaire
To be completed by patients with Medicare

Name: _____ **DOB:** _____ **Medicare #:** _____

Do you have a Medicare HMO/Replacement Plan? ☐ Yes ☐ No

Is this illness/injury due to an accident? ☐ Yes ☐ No

If "YES" date/description of the accident: _____

What is your employment status?

- ☐ Working – Name/Address of Employer? _____
- ☐ Never Worked
- ☐ No Longer Working (but did not retire)
- ☐ Retired

  If Retired, name of former employer:_____

  Retirement Date: _____

What is your Spouse's employment status?

- ☐ Working – Name/Address of Employer? _____
- ☐ Never Worked
- ☐ No Longer Working (but did not retire)
- ☐ Retired

  If Retired, name of former employer:_____

  Retirement Date: _____
- ☐ Does Not Apply – No Spouse

How did you get your Medicare?

- ☐ Age (LGHP = 20+ Employees)
- ☐ Disability (LGHP = 100+ Employees)
- ☐ ESRD *(If ESRD complete next section) (Kidney Disease)*

Do you have insurance coverage through a Large Heath Group Employer? If you have insurance thru an employer or former employer, is the insurance considered a LGHP*? (See section above for LGHP – 65+ 20 Employees = Yes, Disability 100+ Employees = Yes)*

☐ Yes ☐ No

If you have ESRD Medicare, please answer the following questions:

Have you had a Kidney Transplant?

☐ Yes ☐ No If Yes, Date of Kidney Transplant:_____

Are you on Dialysis?

☐ Yes ☐ No If Yes, Date Dialysis Started:_____

Type of Dialysis:

☐ **CAPD** ☐ **Hemodialysis – Center Based** ☐ **Hemodialysis – Home Base**