

Mammography Patient Questionnaire

**Office use only**

Appointment Time: _____

Ordering Provider: _____

Patient ACCT#: _____

Please answer ALL questions

Patient Name: _____

Date: _____

DOB: _____

Age: _____

Height: _____

Weight: _____

Home Number: _____

Ordering PCP: _____

Cell Number: _____

Previous Mammogram at Aylo Health- Imaging Center? Yes No When? _____

What was your age at your first menstrual period? _____ When was your last period? (Date or Age) _____

What was your age at menopause? _____

Have you had a hysterectomy? (Check one) Yes No Partial Complete

How many pregnancies have you had? _____ What was your age when you delivered your first child? _____

Have you ever taken birth control pills or other hormones? Yes No If yes, for how long? _____Are you pregnant or breastfeeding? Yes No Did you breastfeed? Yes NoHave you ever had chemotherapy? Yes No Have you ever had radiation treatments? Yes NoPersonal history of Ovarian Cancer? Yes NoHas anyone in your family had Ovarian Cancer? Yes No

If yes, Who? _____ Age at diagnosis? _____

Personal history of Breast Cancer? Yes NoHas anyone in your family had Breast Cancer? Yes No

If yes, Who? _____ Age at diagnosis? _____

Have you ever had ANY of the following breast surgeries? Check all that apply.

Biopsy (surgical/incision) Rt Lt Date _____ Benign PositiveBiopsy (needle) Rt Lt Date _____ Benign PositiveCyst Aspiration Rt Lt Date _____Lumpectomy (for breast cancer) Rt Lt Date _____Mastectomy Rt Lt Date _____Implants Rt Lt Date _____Breast Reduction Rt Lt Date _____Any other breast procedures? Yes No If yes, please explain _____

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Mammographer Comments:



Mammographer signature: _____

Any symptoms or problems currently? _____

Mammogram Informed Consent

Please read each paragraph carefully and sign and date the form.

- I understand that all screening mammograms performed at Aylo Health include **3D Tomosynthesis Imaging**.
- I understand that a mammogram is only 90% accurate in detecting breast cancer and is only a partial examination for diagnosing breast cancers.
- I understand, based on my clinical symptoms, I may be referred for a diagnostic mammogram, ultrasound or to a surgeon. The diagnostic mammogram and ultrasound is not considered preventative and would be billed as separate studies.
- I understand that I am responsible for getting my results if I have not heard from my physician after 2 weeks.
- I understand periodic breast examinations should be done by a physician.
- I understand if after seeing my physician I continue to have breast problems, regardless of a negative report on the mammogram, I will contact my physician for instructions on further follow up.
- I understand some redness and/or tenderness of my breasts may occur following the mammogram due to the compression device necessary for good images, but these symptoms should be gone within 24 – 48 hours.
- I understand a mammogram does require the use of low dose radiation; therefore, I will inform the technologist if I think I might be pregnant.

PATIENT SIGNATURE

DATE

PATIENT NAME (PLEASE PRINT)

WITNESS

DATE

Authorization For Release Of Mammogram/Ultrasound Images



Date: _____

- My previous Mammogram was done at Aylo Health Imaging Center
- My previous Mammogram was NOT done at Aylo Health Imaging Center

Facility of Previous Mammogram Films:

Facility Name: _____

Street Address: _____

Phone: _____ Fax: _____

CITY STATE ZIP CODE

Last name at time of previous mammogram: _____

***Please note, your exam will be held for 14 days prior to being read by the radiologists. Aylo Health will make all attempts to acquire previous mammogram films for comparison.**

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films/Pathology results/reports** to

**Aylo Health
Imaging at Stockbridge
1100 Hospital Drive
Stockbridge, GA 30281**

Phone: 678-432-6161 Ext. 13144 **Fax:** 678-432-3677

This authorization is valid from the date of my or my representative's signature below and shall expire in 366 days unless otherwise noted by me or my representative.

PATIENT NAME

DATE OF BIRTH

SIGNATURE OF PATIENT

DATE

NAME OF REP.

SIGNATURE

DATE

Releasing facility: please fax this form to Aylo Health, Imaging Services.

Images PowerShared on: _____

Films/Images on CD/DVD Mailed on: _____

No record in our system - Initial _____

Insurance Waiver



Date: _____

Patient Name: _____

Provider Name: _____

I understand the mammogram performed on the above date may not be covered by my insurance company due to:

- It may not have been a full year since my last screening mammogram and I understand my insurance only covers 1 screening per year.
- I am under the age of 40 and I understand mammograms are recommended starting at age 40.
- Provider is not recognized under my insurance plan. I understand that I may be using an out of network provider for these services.
- None of the circumstances listed above apply to me

I elect to receive services today and agree to pay any and all of the balance due related to this procedure if not covered by insurance.

SIGNATURE OF PATIENT OR PERSON REPRESENTED BY SAID INSURANCE PLAN

IF WE CANNOT VERIFY YOUR INSURANCE, YOU WILL BE CONSIDERED SELF PAY