Office Use Only:

APPOINTMENT TIME: _____
ORDERING PROVIDER: _____
PATIENT ACCT#: _____
3D TOMOSYNTHESIS? _____

Mammography Patient Questionnaire

Please answer ALL questions.

Date: _____

Patient Name:_____ **DOB**:_____ **Age**:_____ **Height**:_____
Weight:_____ **Ph#**:_____ **Ordering PCP**:_____ **Ph#**:_____

Previous Mammogram? Yes_____ No_____ **If Yes, Where**?_____ **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_____ No_____
Have you ever had chemotherapy? Yes_____ No_____ **or radiation treatments**? Yes_____ No_____
Personal history of Ovarian Cancer? Yes_____ No_____
Has anyone in your family had Ovarian Cancer? Yes_____ No_____
If yes, Who?_____ **Age at diagnosis**?_____
Personal history of Breast Cancer? Yes_____ No_____
Has 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_____	Positive_____
Biopsy (needle)	Rt_____	Lt_____	Date_____	Benign_____	Positive_____
Cyst 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**_____
_____
Any symptoms or problems currently?_____
_____

FOR OFFICE USE ONLY

Mammographer Comments:

Mammographer Signature: _____

MAMMOGRAM INFORMED CONSENT

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

- 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 are 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's Signature Date

_____

Patient's Name (Please Print)

_____ _____/_____/_____

Witness Date

Aylo Health - Imaging at Stockbridge
1100 Hospital Drive, Stockbridge, GA
30281 Phone: 678-432-6161 Fax:
678-432-3677

AUTHORIZATION FOR RELEASE OF MAMMOGRAM/ULTRASOUND IMAGES

Date: _____/_____/_____

Facility of Previous Mammogram Films:

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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 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** to

Aylo Health - Imaging at Stockbridge
1100 Hospital Drive
Stockbridge, GA 30281
Ph. 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 at Stockbridge.

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 are considered Self Pay

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