



Please fax the completed form to: **912.691.9321**

Mobile Mammography-Patient Information

Appointment Date: ____/____/____

Legal Name: _____ Mobile site location: _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

EmailAddress _____

The best time to contact me is: A.M. P.M.
Preferred Phone Home Work Cell May we leave a message: Yes No

D.O.B. ____/____/____ Sex _____ Race _____ Ethnicity: Hispanic/Latino: Yes No

Language: _____ Religion _____

Last four digits of Social Security Number _____ Marital Status: _____

Employer: _____ Employer Address _____

Occupation _____ Employer Phone: _____

Person to Contact _____ Relation _____ Phone# _____

Insurance Information

Name of Insurance Plan: _____

Subscriber Name: _____

Last

First

Subscriber Relation to Patient _____ Gender _____

DOB: ____/____/____ SSN# _____ Policy ID Number _____

Group Name #: _____ Group # _____

Eligibility/Benefits Phone Number # _____

Claims Address: _____

Questionnaire

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.

1. Are you having any problems with your breasts? Yes _____ No _____ (e.g., lumps or nipple discharge)

2. Have you ever been treated for breast cancer or had any type of breast surgeries? Yes _____ No _____

3. Is this your first mammogram? Yes _____ No _____

Place and Date of most recent mammogram _____

Place

Date

Name of Primary care Physician or OB/Gyn: _____ Address: _____

Phone: (____) _____ Fax: (____) _____