MOBILE MAMMOGRAPHY SCREENING CENTER

MUST BE 40 YEARS OR OLDER WITHOUT A PRIOR BREAST ISSUE

SCREENINGS WILL ONLY BE PROVIDED AFTER ONE YEAR AND ONE DAY FROM THE WOMEN'S LAST SCREENING DATE

SCREENING DATE/LOCATION______________________________________ : ________________________

PATIENT DEMOGRAPHIC INFORMATION:

PATIENT NAME:____

ADDRESS: ____

CITY, STATE, ZIP ____

HOME PHONE#____________________________________ CELL PHONE_________________________________

EMPLOYER:____

PHONE#____

D.O.B:___ ___/___ ___/___ ___ ___RACE:_____________________MARITAL STATUS:___________________ _

LAST 4 DIGIT OF SOCIAL SECURITY #____ ____ ____ ____

LANGUAGE SPOKEN IN THE HOME____

EMERGENCY CONTACTS:

NAME:_____________________________ RELATIONSHIP:________________ PHONE_________________________

NAME:_____________________________RELATIONSHIP:________________ PHONE_________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME__________________________SECONDARY INSURANCE NAME_________________

POLICY HOLDER NAME:______________________________POLICY HOLDER NAME_________________________

SUBSCRIBER DOB (if different than patient) ____

INSURANCE ID # ______________________________________ INSURANCE ID #______________________________

GROUP #____ GROUP #______________________________________

ADDRESS ____ ADDRESS______________________________________

PHONE# ____ PHONE#_______________________________________

DO YOU HAVE A WRITTEN ORDER FROM A PHYSICIAN ☐ YES ☐ NO

DO YOU WANT YOUR RESULTS SENT TO YOUR PRIMARY CARE PHYSICIAN ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN:_______________________________________PHONE # _________________________

Email this completed form to screening@livingbravetbc.org, **no later than October 3rd**.
Please bring a Picture ID, Insurance Card and Prescription to your screening appointment.