ILENE SHAPIRO
COUNTY EXECUTIVE

EMPLOYEE INFORMATION

Please read information below

MAMMOVAN

Breast cancer is the second most common form of cancer in women, affecting one in every eight women in the United States.

We believe the key to beating this statistic is detecting breast cancer early, yearly mammograms, monthly self-breast exams and regular clinical examinations.

Please take advantage of our Mammogram Service for County Employees.

QUESTIONS CONTACT

PHONE:
(330) 434-1348

EMAIL:
TheWellnessTeam@summitoh.net

LOCATION

The Wellness Team
1180 S. Main Street, Suite 378
Akron, Ohio 44301

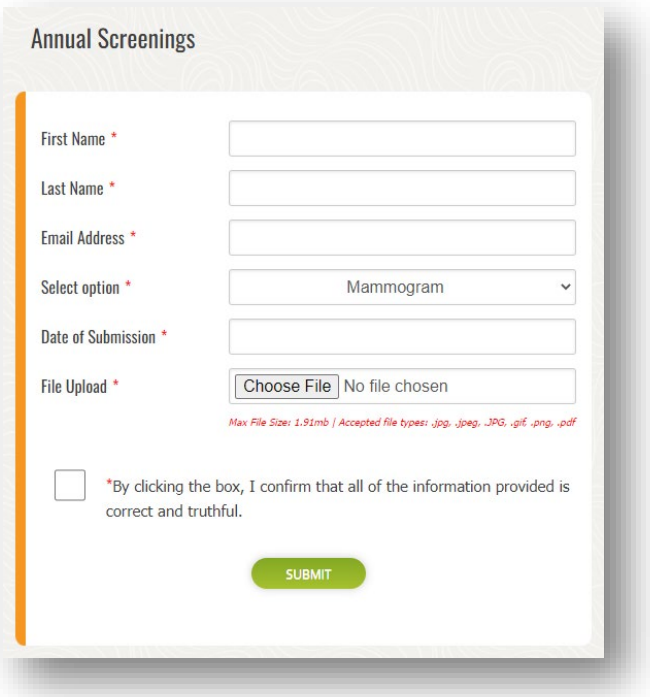
PAPERWORK

The paperwork for your mammogram must be filled out completely, including your doctor's contact information. The information you submit is used by the vendor to turn into your doctor.

SUBMIT

Log into Virgin Pulse, click on "Benefits", on the menu bar, choose what type of documentation you are submitting then click on "Start Now"

Any questions about getting your points, please contact your Wellness Coordinator or the Wellness Team.



Tiffany Breast Care Center *Mobile*

Patient History

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Ph # _____ Work or Cell Ph # _____

Today's Date _____

You must provide your doctor's complete name, address, phone and FAX NUMBER TO SEND RESULTS

Doctor	Doctor
Address	Address
City State Zip	City State Zip
Phone #	Phone #
Fax #	Fax #

Please Circle Answers

# of Films _____

Lump in Breast	Y / N	New Finding	Y / N	Which Breast	L / R
Localized Discomfort, Pain, Soreness	Y / N	New Finding	Y / N	Which Breast	L / R
Discharge from Nipple	Y / N	New Finding	Y / N	Which Breast	L / R Bloody Y/N
Inverted Nipple	Y / N	New Finding	Y / N	Which Breast	L / R
Previous Breast Cancer	Y / N	New Finding	Y / N	Which Breast	L / R

Explain: _____

Family History of Breast Cancer Y / N If yes, please check any/all that pertain: _____ Mother _____ Maternal Grandmother _____ Sister _____ Maternal Aunt/s _____ Daughter

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Number of Pregnancies ___ Age at First Pregnancy ___ Did You Breastfeed? ___ Currently Breast Feeding ___

Age at First Period _____ Age at Menopause (if applicable) _____ Do You Take Hormones Y / N

Do you Practice Self Breast Examination Y / N Previous Breast Surgery Y / N Which Breast L/R

If prior breast surgery, When _____ Why _____

Do you have breast implants ? Y / N Have you had a Breast Reduction ? Y / N

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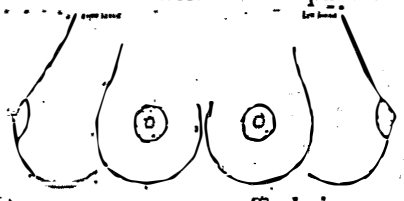
⇩ ⇩ ⇩ Patients do not write in the space below ⇩ ⇩ ⇩



Technologist _____ Technique _____

Degree/ Obliquity _____ Compressed thickness _____

Cell Sensor Placement _____ Screening _____ Diag _____

Bilat _____ Unilat L _____ Unilat R _____

Infection control/disinfection performed _____ initials

Previous Mammogram ? ____ Yes or ____ Baseline

If Yes, When _____ Month _____ Year

What Facility ? _____

Patient Signature _____

Date _____

Patient Number _____

MAHONING VALLEY IMAGING, LTD

PATIENT REGISTRATION FORM

(PLEASE PRINT) Referred By _____

Patient Information (To be completed by the Patient or Responsible Party)

Name _____ Sex ____ Age ____ Birthdate _____

Address _____ Marital Status _____

City _____ St _____ Zip _____

Home Phone _____

Spouse's Name _____

To be Completed by Responsible Party (If other than patient)

Name _____ Relationship to Patient _____

Address _____ DOB _____

City _____ St _____ Zip _____

Primary Insurance		Secondary Insurance	
☐ Copy of Insurance Cards Attached		☐ Copy of Insurance Cards Attached	
Insurance Name	Effective Date	Insurance Name	Effective Date
Address	Policy/Group		

I hereby authorize the above Practice to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from any attending physician and/or such physicians as may be selected by my attending physician, at his or her discretion, for the purpose of obtaining further diagnosis and/or treatment which his or her believes is indicated.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I am responsible for any referrals and/or authorizations required by my insurance Company. I understand I am financially responsible for any balance not covered by my insurance.

I understand that the above practice is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for the non-covered services.

I understand that the above Practice is not in the business of extending credit and I agree to pay the above practice at the time the bill is presented. If prompt payment is not made, the above practice may take action to collect the charges, which includes payment being arranged to my credit card.

Signature _____ Date _____