AdventHealth

MOBILE MAMMOGRAPHY
Patient Registration Form

Appointment Date:____________________ Appointment Time: ____________________

Patient Name: ____

Mailing Address: ____

City:____________________ State:______________ Zip:______________

Phone:____________________ Date of Birth:____________________

INSURANCE INFORMATION

Insurance Company: ____

Member ID:____

Group Number:____

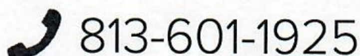
Relationship to Policy Holder: ____

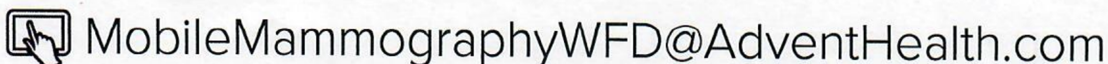
Physician's Full Name:____

Street: ______________________________ Suite: ______________

City: ____________________ State:______________ Zip:______________

Phone:____________________ Fax:____________________





WD-10535

Form of Written Acknowledgment of Receipt of Notice of Privacy Practices

By signing this Written Acknowledgment of Receipt of Notice of Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of the Notice of Privacy Practices.

____
Patient or Legal Representative Signature

____
Printed Patient or Legal Representative Name

____
Date

AdventHealth Mobile Mammography

Authorization to Release Previous Breast Imaging Records

To AdventHealth West Florida Imaging

Patient Name: ______________________________ Date of Birth: ________________

Phone Number: ____

I herby authorize to obtain from: (Facility Name/ Address/ Phone #)

Facility/ Organization: ____

Address: ____

Phone #: _________________________ Fax #: ___________________________

These images and/or reports will be used to compare with my present examination

___Mammogram Images and Reports ____Breast Ultrasound & Reports ____Breast MRI & Reports

Please Power Share if possible- Send reports/ images

AdventHealth West Florida Imaging
8702 Hunters Lake Dr Suite 150,
Tampa, FL 33647
Fax 813-436-8437
Office 813-601-1925

___I understand I may revoke this authorization at any time by notifying the above referenced person/ physician organization in writing.

___I understand the revocation does not apply to information that has already been released in responded to this authorization. Unless revoked, this authorization will expire (12) months from the date of this authorization.

___I understand that the information in my medical record may include information about my medical history, diagnoses, and/ or treatment.

Patient Signature: ____________________________________ Date: _________________

Patient Name: ______________________________________