communityclinic
A HEALTHCARE MINISTRY OF ST. FRANCIS HOUSE NWA

BREASTCARE APPLICATION Account# _____

Completed by_____

Date_____ Scheduled by_____

Patient Information:

Patient's **FULL** Name				Gender	Female	Male
Address				Date of Birth		
City				Marital Status	Single	Married
Zip Code	Address Type:	Home	Work	Insurance	Yes	No
County				Name/Plan		
Medicaid #				SSN #		
Home/ Day Phone:				Cell/ Evening Phone:		
Emergency Contact Person						
Emergency #						
Race				Ethnicity		

BreastCare Eligibility Information:

Gross Monthly Household Income: ***You must count alimony, Social Security, and retirement as part of your income. Do not include high school or college student earnings.***	$_____	
Household Size		
Has the patient had Breast Care? If yes, Breast Care# _____ Where? _____	Yes	No
Has the patient ever have a mammogram? Date of Last Mammogram _____ Normal?	Yes Where? Yes	No _____ No
Has the patient ever had a Pap Test? Date of Last Pap Test _____ Normal?	Yes Where? Yes	No _____ No
Check if patient has symptoms ❑ Breast Mass	❑ Abnormal Vaginal Bleeding	
Is the patient covered by Medicare Part A or Part B?	Yes	No

Medical History

Do you currently have a biopsy diagnosis of breast or cervical, carcinoma-in-situ, or CIN or CIN III?	Yes	No
If yes, do you need treatment for the diagnosis?	Yes	No
Has the patient had a hysterectomy?	Yes	No

Other Patient Information

Education	Language

Appointment Date CBE/ Pap Test

Initial Appointment Date		
Primary Care Provider (PCP) at Community Clinic		
Type of Exam		
Mailing Address the same as Physical Address	Yes	No