Date of Registration: _____

Ashland County Cancer Association

Mammogram Registration & Screening Information

Name: _____ Phone Number: _____

Date of Birth: _____ Twp.: _____

Address: _____ City & Zip: _____

Email: _____

Mammogram Information:

Date of your last mammogram: _____ Location: _____

Are you experience any issues with your breast? _____

Any breast surgeries? □ Yes □ No | Do you currently have breast implants? □ Yes or □ No

Past Mastectomy? □ Single □ Double | Do you have a physician's order for a mammogram? □ Yes □ No

Family History:

Family history of breast cancer: □ Yes or □ No | Relation: (mom, aunt, etc.): _____

Physician's Information:

Physician's Name/Practice: _____

Address: _____

Phone: _____

Demographic information:

Number of People in Household: _____ Annual Income: _____

Employment: □ Employed □ Unemployed □ Retired □ Disabled

Veteran: □ Yes □ No | Insurance: □ Yes □ No

Authorization of release of information:

I request & authorize that the information provided be released and exchanged with the following agencies as to provide necessary care to me through the Ashland County Cancer Association's Mammogram Program.

**Breast & Cervical Cancer Project or your physician as identified on this registration*

Signature: _____ Date: _____

Questions/Submit Registration Form: Email: ashlandcocancer@gmail.com | Mail: Ashland Co. Cancer Association, 1011 East Main Street, Suite B, Ash, OH 44805 | Fax: 419-281-5743 | Office: 419-281-1863