Women's Imaging
CENTER
Lexington Medical Center

2728 Sunset Boulevard, Suite 1, West Columbia, South Carolina 29169 • Telephone: (803) 791-2653

Mobile Preregistration Form

PLEASE FILL OUT THIS FORM COMPLETELY

I have selected a: ☐ 2D Mammogram ☐ 3D Mammogram

Appointment Date:_____ **Time:**_____ **Location:**_____

Have you had a previous mammogram: ☐ Yes ☐ No **If yes, date of last mammogram:**_____

Location of last mammogram:_____

Patient Name:_____
First Middle Last Maiden

Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Phone Number:(_____)_____ Other Phone Number:(_____)_____ SSN:_____

Sex: ☐ Female ☐ Male Birth Date:_____ Age:_____ Religion:_____

Race: ☐ Black/African ☐ Asian/Pacific Islands ☐ White/Caucasian ☐ Hispanic/South American ☐ American Indian/Alaskan ☐ Other

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widow/Widower ☐ Life Partner ☐ Unknown

Name of your physician:_____
First Middle Last

Physician's Phone Number: (_____)_____ **Address if out of state:**_____

Patient Employer:_____ Occupation:_____ Phone Number:(_____)_____

Company Address:_____ City:_____ State:_____ Zip Code:_____

Patient Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Active Military ☐ Retired What year:_____ ☐ Self Employed ☐ Unknown

Next of kin or emergency contact name:_____ Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:(_____)_____ Other Phone Number:(_____)_____

CONTINUED ON NEXT PAGE

Primary Insurance Carrier Name:_____ Insurance Phone Number:(_____)_____

Policyholder Name:_____ DOB:_____ Relationship to Patient:_____

Claims Address:_____ City:_____ State:_____ Zip Code:_____

Policy Number:_____ Group Number:_____

Employed by what company:_____ Company Phone Number:(_____)_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Active Military ☐ Retired What year:_____ ☐ Self Employed ☐ Unknown

Secondary Insurance Carrier Name:_____ Insurance Phone Number:(_____)_____

Policyholder Name:_____ DOB:_____ Relationship to Patient:_____

Claims Address:_____ City:_____ State:_____ Zip Code:_____

Policy Number:_____ Group Number:_____

Employed by what company:_____ Company Phone Number:(_____)_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Active Military ☐ Retired What year:_____ ☐ Self Employed ☐ Unknown

PLEASE BRING YOUR INSURANCE CARD OR COPY TO YOUR APPOINTMENT.