WOMEN'S WAY DEMOGRAPHICS

NORTH DAKOTA DEPARTMENT OF HEALTH
CANCER PREVENTION AND CONTROL
SFN 54024 (4-2016)

ENROLLMENT

1. Enrollment Site	2. County of Enrollment	3. Type ☐ Enrollment ☐ Re-Enrollment	Date (MM/DD/YYYY)
4. Appointment Location/Provider			Appointment Date (MM/DD/YYYY)

IDENTIFICATION

6a. Social Security Number	6b. Alternate ID Number	7. Name (Last, First, Middle Initial)
8a. Maiden Name	8b. Any Other Last Name Used	9. Date of Birth (MM/DD/YYYY)

10. Race(s) (check all that apply)
☐ White ☐ Asian ☐ Am. Indian ☐ Eskimo
☐ Black ☐ Pacific Islander ☐ Native Hawaiian ☐ Unknown

11. Hispanic/Latino Origin
☐ Yes ☐ No ☐ Unknown

MAILING ADDRESS

12. Street or P.O. Box	13. City	14. County	15. State	16. ZIP Code
17. Home Telephone Number	17a. Cell Phone Number	18. Work Telephone Number		

ALTERNATE ADDRESS (Secondary)

19. Street Address	20. City	21. State	22. ZIP Code	23. Alt Telephone No.

DEMOGRAPHICS

24. Client Status
☐ 1. Active ☐ 2. Inactive ☐ 3. Out of Area ☐ 4. Temp Inactive ☐ 5. Deceased

25. Date of Status Change (MM/DD/YYYY)

Status Notes

26. Visit Type
☐ 1. Initial ☐ 2. Rescreen (Annual) ☐ 3. Rescreen (Follow-up)

27. Health Insurance (check all that apply)
☐ 1. None Referred to: ☐ Marketplace ☐ Medicaid Expansion ☐ Other _____
☐ 2. Health Insurance ☐ 3. Medicare A ☐ 4. Other: _____ ☐ 5. Medicaid

Name of Insurance Company	Name of Policyholder	Policyholder Date of Birth (MM/DD/YYYY)
Insurance Benefit Plan Number	Insurance Company Telephone Number	Coverage Dates

28. Household Status
☐ 1. Never Married ☐ 2. Married ☐ 3. Widowed ☐ 4. Divorced/Separated ☐ 5. Domestic Partner ☐ 6. Other:

29. Are you a smoker/tobacco user?
☐ 1. No ☐ 2. Former ☐ 3. Yes

30. Are you interested in quitting at this time?
☐ 1. Yes ☐ 2. No ☐ 3. Not Applicable

31. Are you exposed to second-hand smoke?
☐ 1. Yes ☐ 2. No

32. Referral offered?
☐ 1. Yes ☐ 2. No ☐ 3. Declined ☐ 4. Not Applicable

Comments

33. Education
☐ 1. 8th Grade or Less ☐ 3. High School Graduate/GED ☐ 5. Technical School Graduate ☐ 7. College Graduate
☐ 2. Some High School ☐ 4. Some Technical School ☐ 6. Some College ☐ 8. Unknown

35. Number Living in Household (including yourself)

Total Gross Monthly Household Income (before taxes)

36. Referral Source (check all that apply)
☐ 1. Self ☐ 3. Outreach ☐ 5. TV Campaign ☐ 7. Newspaper
☐ 2. Provider ☐ 4. WW/BCCP Reminder ☐ 6. Radio Campaign ☐ 8. Other: _____

37. Previous Mammogram? ☐ 1. Yes ☐ 2. No	37a. If Yes, Date of Last Mammogram (MM/DD/YYYY)	37b. Implants? ☐ 1. Yes ☐ 2. No
38. Noticed Changes in Breast? ☐ 1. Yes ☐ 2. No	38a. If Yes, Specify Changes ☐ 1. Skin Different ☐ 3. Nipple Discharge ☐ 5. Other: ☐ 2. Lump ☐ 4. Nipple Inversion _____	
39. Do you have a history of breast cancer in your family? (check all that apply) ☐ 1. Mother ☐ 2. Sister ☐ 3. Aunt ☐ 4. Daughter ☐ 5. Grandmother ☐ 6. None ☐ 7. Unknown ☐ 8. Self		
40. Have you been taught breast self-exam? ☐ 1. Yes ☐ 2. No		
41. Previous Pap Test? ☐ 1. Yes ☐ 2. No	41a. If Yes, Date of Last Pap	41b. History of Abnormal Paps? ☐ 1. Yes ☐ 2. No
42. Have you had a Hysterectomy? ☐ 1. Yes ☐ 2. No	42a. If Yes,Reason for Hysterectomy ☐ 1. Cervical Cancer ☐ 2. Unknown ☐ 3. Cervical Pre-Cancer ☐ 4. Non-Cancer	
42b. Do you still have a cervix? ☐ 1. Yes ☐ 2. No ☐ 3. Unknown		

I verify that, to the best of my knowledge, all information I have provided to *Women's Way* is true and accurate.

Signature	Date (MM/DD/YYYY)
Contact Person (list someone NOT in your household, ie., relative, neighbor, friend, etc.)	
Relationship to the Applicant	Telephone Number

Questions? Please contact your Enrolling Site Office at 800.44 WOMEN or 701.328.2306

According to the Privacy Act of 1974, this is to let *Women's Way* clients know that disclosure of a social security number to *Women's Way* is voluntary and it is requested for identification purposes only. Failure to disclose this information will not affect participation in this program.