

WISH ID# _____
 Site Distribution Code _____

PROJECT WISH APPLICATION FORM

Incomplete application will not be considered for enrollment

**** DO NOT COMPLETE THIS FORM IF YOU HAVE HEALTH INSURANCE ****

LAST NAME		FIRST NAME		MI	TODAY'S DATE	
ADDRESS				APT#		DATE OF BIRTH
CITY		STATE		ZIP CODE		AGE
HOME PHONE			WORK PHONE			
SOCIAL SECURITY #		MAIDEN NAME		CELL-PHONE *		EMAIL-ADDRESS
EMERGENCY CONTACT AND RELATIONSHIP				PHONE		
WHAT IS YOUR HOUSEHOLD MONTHLY INCOME? _____		HOW MANY PEOPLE DOES THAT INCOME SUPPORT? _____		COUNTRY OF BIRTH: _____		
				YEARS IN USA: _____		
RACE (check all that apply) <input type="checkbox"/> Black/ African American <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Unknown		ARE YOU HISPANIC OR OF HISPANIC ORIGIN? Yes: <input type="checkbox"/> Hispanic/Black <input type="checkbox"/> Hispanic/White <input type="checkbox"/> No		PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Hindi/Urdu <input type="checkbox"/> French <input type="checkbox"/> Amharic <input type="checkbox"/> Mandarin <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____		
HIGHEST GRADE COMPLETED <input type="checkbox"/> 1st grade – 5 th grade <input type="checkbox"/> 6th grade – 12 th grade <input type="checkbox"/> Some College <input type="checkbox"/> College degree <input type="checkbox"/> Post college degree		DO YOU HAVE BREAST SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If, yes Specify: _____ DO YOU HAVE BREAST IMPLANTS? <input type="checkbox"/> Yes <input type="checkbox"/> No		HOW DID YOU HEAR ABOUT PROJECT WISH? <input type="checkbox"/> Poster/Flyer <input type="checkbox"/> At Work <input type="checkbox"/> Doctor/Nurse Clinic <input type="checkbox"/> Radio <input type="checkbox"/> Outreach Worker <input type="checkbox"/> At Church <input type="checkbox"/> Friend/Relative <input type="checkbox"/> TV <input type="checkbox"/> Newspaper <input type="checkbox"/> Pamphlet <input type="checkbox"/> Other _____		
DATE OF LAST MENSTRUAL PERIOD: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable						
HAVE YOU EVER HAD A PAP SMEAR? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If Yes, Date: _____ WHERE _____ <input type="checkbox"/> Within the past year (1-12 months) <input type="checkbox"/> Within the past 2 years (1-2 years ago) <input type="checkbox"/> Within the past 3 years (2-3 years ago) <input type="checkbox"/> Within the past 5 years (3-5 years ago) <input type="checkbox"/> Over 5 years ago <input type="checkbox"/> Don't know			HAVE YOU EVER HAD A MAMMOGRAM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If Yes, Date: _____ WHERE _____ <input type="checkbox"/> Within the past year (1-12 months) <input type="checkbox"/> Within the past 2 years (1-2 years ago) <input type="checkbox"/> Within the past 3 years (2-3 years ago) <input type="checkbox"/> Within the past 5 years (3-5 years ago) <input type="checkbox"/> Over 5 years ago <input type="checkbox"/> Don't know			
HAS YOUR MOTHER, SISTER, DAUGHTER, OR AUNT EVER HAD CERVICAL CANCER? <input type="checkbox"/> Yes, Relationship: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			HAS YOUR MOTHER, SISTER, DAUGHTER, AUNT OR GRANDMOTHER EVER HAD BREAST CANCER? <input type="checkbox"/> Yes, Relationship: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			
HAVE YOU EVER HAD: <input type="checkbox"/> A hysterectomy Date: _____ <input type="checkbox"/> Cervical Cancer Date: _____ <input type="checkbox"/> Breast Cancer Date: _____ <input type="checkbox"/> Ovarian Cancer Date: _____			DO YOU REQUIRE ANY SPECIAL ACCOMODATIONS DUE TO A DISABILTLITY? (optional) <input type="checkbox"/> Yes; please explain: _____ <input type="checkbox"/> No			
DO YOU SMOKE? <input type="checkbox"/> NO <input type="checkbox"/> YES; If yes, are you interested in classes to help you quit smoking? <input type="checkbox"/> YES NO <input type="checkbox"/>						

*All patients will receive cell phone (text and/or voicemail) or email appointment reminders. Please indicate here if you do not wish to participate in this program. Standard rates apply for text messages.

I do not wish to receive text messages on my cell phone.