CENTER FOR BREAST CARE

William Burak Jr., M.D., FACS
Elena Rehl, M.D., FACS
Catie Bell, MSN-CS, FNP
Phone: 912-350-2700|Fax: 912-350-2715

NEW PATIENT FORM

CONTACT INFORMATION

Patient name: _____ DOB: _____

Address: _____

Home: _____ Work: _____Cell: _____

Referred by: _____

Your primary care physician: _____

Your gynecologist: _____

REASON FOR YOUR APPOINTMENT

☐ Breast lump
☐ Abnormal mammogram
☐ Concern about breast cancer risk
☐ Nipple discharge
☐ New breast cancer
☐ Second opinion
☐ Breast pain
☐ Recurrent breast cancer
☐ Other: _____

Date of your last mammogram: _____ Location: _____

MEDICAL HISTORY

Diabetes	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes	High cholesterol	☐ No ☐ Yes
Arthritis	☐ No ☐ Yes	Kidney/liver disease	☐ No ☐ Yes
Bleeding tendency	☐ No ☐ Yes	Emphysema	☐ No ☐ Yes
Mitral value prolapse	☐ No ☐ Yes	Anemia	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Stroke	☐ No ☐ Yes, Year: ____
Heart disease	☐ No ☐ Yes	Seizures	☐ No ☐ Yes
Thyroid problems	☐ No ☐ Yes	Depression/anxiety	☐ No ☐ Yes
Blood clots	☐ No ☐ Yes	Other: _____	
Cancer	☐ No ☐ Yes If yes, type of cancer: _____		

Previous surgeries/operations and date of procedure: _____

_____

_____

FAMILY HISTORY

Family history of breast cancer	□ No □ Yes	Family member:_____
Family history of ovarian cancer	□ No □ Yes	Family member:_____
Other family history of cancer	□ No □ Yes	Family member:_____
		Cancer Type(s): _____

SOCIAL HISTORY

Marital status: □ single □ married □ separated □ divorced □ widowed

Sexually active? □ yes □ no Male/Female

Do you use:

Alcohol	□ yes □ no	Drinks per week: _____
Tobacco (Currently)	□ yes □ no	Packs per week: _____
Tobacco (Past)	□ yes □ no	Packs per week: _____
Caffeine	□ yes □ no	Drinks per week: _____

MEDICATIONS

Do you take blood thinners □ yes □ no

Please list all medications you are currently taking (including herbal medications, vitamins, over the counter medications, etc.):

1: _____	4: _____	7: _____
2: _____	5: _____	8: _____
3: _____	6: _____	9: _____

Name of your pharmacy: _____

City, State: _____ Phone number: _____

Are you currently suffering from or have you any prior history of:

CONSTITUTIONAL SYMPTOMS

Good General Health Lately	□ No □ Yes
Recent Weight Change	□ No □ Yes
Fever	□ No □ Yes
Fatigue	□ No □ Yes

EYES

Eye Disease or Injury	□ No □ Yes
Blurred or Double Vision	□ No □ Yes
Glaucoma	□ No □ Yes

EAR, NOSE, MOUTH, AND THROAT

Hearing Loss or Ringing	□ No □ Yes
Earaches or Drainage	□ No □ Yes
Chronic Sinus Problem or Rhinitis	□ No □ Yes
Nose Bleeds	□ No □ Yes
Mouth Sores	□ No □ Yes
Bleeding Gums	□ No □ Yes
Sore Throat or Voice Change	□ No □ Yes
Swollen Glands in Neck	□ No □ Yes

CARDIOVASCULAR

Chest Pain or Angina Pectoris	□ No □ Yes
Palpitation	□ No □ Yes
Shortness of Breath with Walking or Lying Flat	□ No □ Yes
Swelling of Feet, Ankles or Hands	□ No □ Yes

RESPIRATORY

Chronic or Frequent Coughs	□ No □ Yes
Spitting Up Blood	□ No □ Yes
Shortness of Breath	□ No □ Yes
Asthma or Wheezing	□ No □ Yes

GASTROINTESTINAL

Loss of Appetite	□ No □ Yes
Change in Bowel Movement	□ No □ Yes
Nausea or Vomiting	□ No □ Yes
Frequent Diarrhea	□ No □ Yes
Painful Bowel Movements or Constipation	□ No □ Yes
Rectal Bleeding or Blood in Stool	□ No □ Yes
Abdominal Pain or Heartburn	□ No □ Yes
Peptic Ulcer (Stomach or Duodenal)	□ No □ Yes

GENITOURINARY

Frequent Urination	□ No □ Yes
Burning or Painful Urination	□ No □ Yes
Blood in Urine	□ No □ Yes
Incontinence or Dribbling	□ No □ Yes
Kidney Stones	□ No □ Yes

MUSCULOSKELETAL

Joint Pain	□ No □ Yes
Joint Stiffness or Swelling	□ No □ Yes
Weakness of Muscles of Joints	□ No □ Yes
Muscle Pain or Cramps	□ No □ Yes
Back Pain	□ No □ Yes
Cold Extremities	□ No □ Yes
Difficulty Walking	□ No □ Yes

INTEGUMENTARY

Rash or Itching	□ No □ Yes
Change in Skin Color	□ No □ Yes
Change in Hair or Nails	□ No □ Yes
Varicose Veins	□ No □ Yes

NEUROLOGICAL

Frequent or Recurring Headaches	□ No □ Yes
Light Headed or Dizzy	□ No □ Yes
Numbness or Tingling Sensations	□ No □ Yes
Tremors	□ No □ Yes
Memory Loss or Confusion	□ No □ Yes
Insomnia	□ No □ Yes

ENDOCRINE

Excessive Thirst or Urination	□ No □ Yes
Heat or Cold Intolerance	□ No □ Yes
Skin Becoming Dryer	□ No □ Yes

HEMATOLOGIC/LYMPHATIC

Slow to Heal After Cuts	□ No □ Yes
Bleeding or Bruising Tendency	□ No □ Yes
Anemia	□ No □ Yes
Phlebitis	□ No □ Yes
Past Transfusions	□ No □ Yes
Enlarged Glands	□ No □ Yes

Are you of Jewish Decent?	□ No □ Yes
Number of Pregnancies_____ Number of Miscarriages_____	
Age at First Period_____	
Age at Delivery of Your First Child_____	
Did you breast feed?	□ No □ Yes
Have you gone through menopause?	□ No □ Yes
Have you had a hysterectomy?	□ No □ Yes
Age_____ Reason_____	
Have your ovaries been removed?	□ No □ Yes
Have you ever taken birth control pills?	□ No □ Yes
How many years? _____	
Have you ever taken estrogen?	□ No □ Yes
How many years? _____ When did you stop? _____	
Have you had any prior breast biopsies?	□ No □ Yes
How many? _____ Were any atypical?	□ No □ Yes

History of Skin Reaction or Other Adverse Reaction to:

Penicillin	□ No □ Yes
Morphine, Demerol, or Other Narcotics	□ No □ Yes
Novocaine or Other Anesthetics	□ No □ Yes
Aspirin or Other Pain Remedies	□ No □ Yes
Iodine, Methiolate or Other Antiseptic	□ No □ Yes
Other Drugs/Medications	□ No □ Yes

Please list

_____

_____

_____

Date: _____ **Reviewed By:** _____

Curtis & Elizabeth Anderson Cancer Institute
at Memorial Health University Medical Center

HIPAA / Office Financial Policy / Treatment and Release of Information Form

MR#_____ Patient Name: _____ Date:_____

PRECERTIFICATION AND REFERRALS

If your insurance company requires preadmission certification or office referrals, it is your responsibility to see that we notify your insurance company prior to all admissions or office visits. Any charges not covered as a result of non-certification will be your responsibility.

OFFICE FINANCIAL POLICY

INSURANCE AUTHORIZATION: I request that payment under the medical insurance program be made to the provider for any bills for services rendered to me during the effective period of this authorization. I authorize this provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or related Medicare claim. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims submitted by the provider on my behalf.

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility / physician in network with the insurance plan to Memorial Health University Physicians. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs, and reasonable legal fees.

PERMISSION FOR TREATMENT AND RELEASE OF INFORMATION

The signature below serves as authorization for medical treatment by physicians, physician's assistants, nurse practitioners, or nurses utilized by Memorial Health University Physicians and any affiliates (MHUP) for the named patient and for MHUP staff to get information about me from any medical care provider and give information about me to any medical care provider to assist with my care and treatment. It also provides authorization for MHUP to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance

I acknowledge receipt of MHUP's **Notice of Privacy Practices** which details how the patient's Personal Health Information may be used and disclosed as permitted under Federal and state law. I have read and understand the contents of the notice. I also acknowledge that the information on this form is complete and correct to the best of my knowledge and that I have read and understand the information above concerning **Precertification of Referrals**, **Office Financial Policy** and **Permission for Treatment and Release of Information**.

PATIENT SIGNATURE_____ DATE _____

MHUP TEAM MEMBER _____

Reason, if known, why acknowledgment was not obtained. _____

Curtis & Elizabeth Anderson Cancer Institute
at Memorial Health University Medical Center

Communication to Our Patients

MR#_____ Please Print Name _____

How do you want us to communicate with you?

The HIPAA Final Privacy Rule permits an individual to request that communications from our office be received in a confidential manner. You may ask to be contacted in a certain way, such as, only contacting by mail or at a specific telephone number.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Work telephone:_____
- ☐ O.K to leave message with detailed information on voice mail or with _____
- ☐ Leave message with call back number only
- ☐ Written communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office
- ☐ O.K to fax to this telephone number:_____
- ☐ O.K. to e-mail to this email address: _____

Persons Involved in Your Care

The HIPAA Final Privacy Rule provides you the right to agree or object to the use or disclosure of information to a family member or close friend who is involved in your care.

You may leave messages with, discuss my treatment, appointments, or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Memorial Health University Physician (MHUP) Practices will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this does not apply to medical providers. I can edit this list at any time by providing, in writing, any changes to the practice.

PLEASE PRINT: Name	**Contact number**	**Relationship**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date