Registration Form

Medical Record # _____

Form Must be Completed in its Entirety

Last Name	First Name	MI	DOB	Sex M / F	Maiden Name

Street Address / Mailing Address	City	State	Zip

Home Phone	Day Phone	Cell Phone	Social Security #
( )	( )	( )	

Email Address	Employer

Marital Status Mar. Wid. Sing. Div. Sep. ☐ ☐ ☐ ☐ ☐	Spouse Name	Spouse Date of Birth

In Case of Emergency – Notify	Relationship	Telephone #	Address City State ZIP

Have you or any member of your immediate family been examined here before? Yes ☐ No ☐	If Yes, give name	Have you been in the Clinic under a different name? Yes ☐ No ☐	If Yes, give name

Primary Language (select one)
☐ English ☐ Spanish ☐ Other – Please List _____

Ethnicity	Race		
☐ Hispanic or Latino	☐ White	☐ Black or African American	☐ Asian
☐ NOT Hispanic or Latino	☐ Other _____	☐ American Indian	☐ Hispanic

Guarantor or Responsible Party for Household
(Must be Completed)

Last Name	First Name	MI	Social Security #	Relationship to Patient Self ☐ Spouse ☐ Parent ☐ Other ☐

Telephone Number	DOB	Mailing Address	City	State	ZIP
( )					

Occupation	Employer	Address	Phone

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Employer: _____ Effective Date: _____

Secondary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Employer: _____ Effective Date: _____

Tertiary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Employer: _____ Effective Date: _____

(PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST)

(over)

INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We are required by law to protect the privacy of your health care information, offer a copy of our Notice of Privacy Practices, and to follow the guidelines described in that notice. Your signature acknowledges you have been offered this notice. If you wish to receive a copy of your health care information you may do so by contacting our Medical Records Department or our Security Officer. Occasionally we may send you information about products or services that we believe may be beneficial to you. You may contact our Security Officer to request that these materials not be sent to you.

FINANCIAL POLICY

Our office is committed to providing quality and cost effective healthcare to our patients. In today's insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our speciality. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. Insurances reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pays, deductibles, and co-insurance amounts not covered by a secondary insurance policy along with the entire amount of any non-covered service. We appreciate payment for services at the time they are rendered. For your convenience, we accept cash, personal checks, Visa, and MasterCard. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account. I understand that interest of 1% per month compounded annually will be added on all unpaid balances over 90 days. I understand I am responsible for my spouse/dependent charges.

X SIGNATURE: _____ **DATE:** _____

PREVENTATIVE CARE

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the scheduled encounter and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and /or diagnosis codes in order to get the claim paid by the insurance company.

To protect the healthcare team who may accidentally be exposed to my blood or body fluids, I consent to have my blood tested for transmissible disease (such as hepatitis virus, HIV (AIDS), others). If this testing is necessary it will be done at no charge. Your physician will inform you if this should become necessary.

X SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION (optional)

You may share the following health care information with:

Name: _____ Relationship: _____

Please check all that apply:

☐ All health care information in my medical record. ☐ Insurance and billing information

☐ Health care information in my medical record relating to the following treatment:_____

☐ Other (appointments, test results, etc.) _____

This authorization ends:

☐ In 1 year from the date signed or upon written revocation.

X SIGNATURE: _____ **DATE:** _____

MEDICAL QUESTIONNAIRE

NAME: _____ DOB: _____

If you do not understand a question or you do not feel comfortable in answering a question, leave it blank and go on to the next question. Some questions may not apply to you.

AGE: _____

DATE OF LAST MAMMOGRAM: _____ REFERRING MD _____

DATE OF LAST BREAST ULTRASOUND: _____ PRIMARY MD _____

PAST MEDICAL HISTORY

ILLNESSES:

			DATE DISCOVERED
Yes _____	No _____	High blood pressure	_____
Yes _____	No _____	Diabetes	_____
Yes _____	No _____	Heart problems	_____
Yes _____	No _____	Cancer (type) _____	_____
Yes _____	No _____	Stroke	_____
Yes _____	No _____	Blood clots	_____
Other: _____			_____

CURRENT MEDICATIONS

Name	Amount and frequency taken	Name	Amount and frequency taken

HERBAL, VITAMIN OR NUTRITIONAL THERAPIES

Name	Amount and frequency taken	Name	Amount and frequency taken

ALLERGIES

Medication or substance	Describe reaction or symptom

PAST SURGERIES (check those that you have had)

		DATE (year)			DATE (year)
_____	C-section	_____	_____	Left Breast Biopsy	_____
_____	Removal of ovary	_____	_____	Right Breast Biopsy	_____
_____	Removal of uterus	_____	_____	Tubal Ligation	_____
_____	Other: _____				_____

OB-GYN HISTORY

Age at first menstrual period. _____

How many pregnancies have you had? _____

How many children have you given birth to? _____

Age at first delivery? _____

Date of last menstrual period? _____

Date of last Pap Smear? _____

Have you taken estrogen or female hormones in the last 10 years? _____

Date Started? _____

Date Stopped? _____

SOCIAL HISTORY

Occupation _____

Martial status ___ Never Married ___ Married ___ Divorced ___ Widowed

Where do you currently live? City: _____ State: _____

Do you smoke cigarettes now? _____ Yes _____ No

Have you smoked in the past? _____ Yes _____ No

When did you start? Date: _____

When did you quit? Date: _____

Do you drink alcohol? _____ Yes _____ No Quantify _____

FAMILY HISTORY

Is there anyone with breast cancer in you blood family? If so, list them by their relation to you, their age and when the cancer was found.

Relation:	Age when cancer was discovered	Age at Death

Are there any women with ovarian cancer in your blood family? If so, list them by their relation to you, their age and when the cancer was found.

Relation:	Age when cancer was discovered	Age at Death

Father's age _____ Alive? _____ Yes _____ No

Cause of death _____ Age at death _____

Mother's age _____ Alive? _____ Yes _____ No

Cause of death _____ Age at death _____

Brothers:			Sisters:		
Age	Alive	Illnesses	Age	Alive	Illnesses

Children:		
Age	Sex	Health

Race

___ American Indian/Alaskan Native

___ Asian

___ Native Hawaiian / Pacific Islander

___ Black or African American

___ White

Ethnicity:

___ Hispanic or Latino

___ Not Hispanic or Latinc

HEALTH REVIEW (last 3 months):

		YES	NO
GENERAL:			
	Weight change, greater than 5 lbs?	_____	_____
	Persistent fatigue:	_____	_____
SKIN:			
	Any new skin rashes, lumps or bumps?	_____	_____
	Hot flashes?	_____	_____
EYES:			
	Recent vision change?	_____	_____
MOUTH:			
	Sore throat?	_____	_____
	Sore mouth?	_____	_____
NECK:			
	New lumps?	_____	_____
	Thyroid problems?	_____	_____
LUNGS:			
	Cough?	_____	_____
	Shortness of breath?	_____	_____
HEART:			
	Chest pain?	_____	_____
	Ever been told you had a heart murmur?	_____	_____
	Abnormal EKG?	_____	_____
GASTROINTESTINAL:			
	Nausea or vomiting?	_____	_____
	Constipation?	_____	_____
	Change in bowel habits?	_____	_____
	Change in appetite?	_____	_____
	Any liver or colon problems?	_____	_____
GENITOURINARY:			
	Problems with urination?	_____	_____
	Vaginal dryness?	_____	_____
JOINTS / EXTREMITIES:			
	Any bone or joint pain or stiffness?	_____	_____
	Arm swelling / lymphedema?	_____	_____
	Ever had a blood clot?	_____	_____
NEUROLOGIC:			
	Have you ever had a seizure?	_____	_____
	Do you have weakness of an arm, leg or other part of your body?	_____	_____
BLOOD:			
	Any history of anemia or blood disorder?	_____	_____
PSYCHOLOGICAL:			
	Have you ever been treated for depression or anxiety?	_____	_____