The Breast Clinic
918 Mar Walt Drive
Ft. Walton Beach, FL 32547
(850) 863-2006

DATE: _____

Medical Record #: _____

Referring Dr.: _____

Referring Dr. Fax #: _____

NAME: _____ _____ _____
Last First MI

DATE OF BIRTH: _____ AGE: _____

1. Are you **PREGNANT** now or is there a possibility that you could be pregnant? ☐ YES ☐ NO
2. How many **children** have you had? _____ How old were you when you had your first child? _____
3. Have you had a prior mammogram? ☐ YES ☐ NO IF YES, when? _____ and where? _____
4. Are you having any breast problems NOW? ☐ YES ☐ NO **IF YES**, mark the problem(s) below.
   a. Distinct lumps in either breast? ☐ Right ☐ Left
   b. Lumpiness (fibrocystic changes)? ☐ Right ☐ Left TECH INITIALS _____
   c. Discomfort, pain or soreness? ☐ Right ☐ Left
   d. Discharge from nipple? ☐ Right ☐ Left How long and what color? _____
5. Are you taking **Hormones**? ☐ YES ☐ NO If YES, for how long? _____
6. Have **YOU** had cancer of the: ☐ None ☐ Breast ☐ Uterus ☐ Ovaries ☐ Other _____
7. Do you have a **FAMILY HISTORY** of breast cancer? ☐ YES ☐ NO **IF YES**, please fill in boxes below.

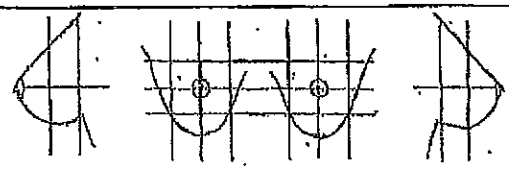
☐ Mother	☐ Sister	☐ Daughter	☐ Grandmother	☐ Aunt	☐ Cousin
@ Age____	@ Age____	@ Age____	@ Age____	@ Age____	@ Age____

8. Please mark if **YOU** have previously had any of the Breast Procedures below. ☐ NONE
   a. **Needle Biopsy** ☐ Right ☐ Left When? _____ b. **Surgical Biopsy** (not cancer) ☐ Right ☐ Left When? _____
   c. **Cyst Aspiration** ☐ Right ☐ Left When? _____ d. **Implants** ☐ Right ☐ Left When? _____
   e. **Reduction** ☐ Right ☐ Left When? _____ f. **Lumpectomy (Cancer)** ☐ Right ☐ Left When? _____
   g. **Mastectomy** ☐ Right ☐ Left When? _____ h. **Radiation** ☐ Right ☐ Left When? _____

X PATIENT SIGNATURE: _____

I hereby declare that the information provided in this form is true and complete to the best of my knowledge.

For Office Use Only
Tech Comments:



Right Breast Left Breast

What was the age of your first menstruation?
When was your last menstruation?
What was the age of your first pregnancy and how many children did you deliver?
How many months total have you breast fed?
How many pregnancies have you had?
Are you currently having any menopausal symptoms?_____ Hot Flashes?_____Night Sweats?_____Emotional Ups & Downs?_____Vaginal Dryness?_____Loss of Interest in Sex?_____Pain with Sex?_____

If you have a family history of breast cancer, is it on your:
Mother's Side _____Father's Side_____Both Sides_____

Smoke? ____ How many cigarettes per day? ____ How long have you or did you smoke?_____ Still smoking?_____ Want to Quit? _____ Have you tried to quit in the past?_____ Are you using nicotine patches, gum, or other medications to quit?

Drink alcohol? Never____ Occasional _____ How many servings per week? _____
How many servings per day of coffee_____ tea_____sodas_____water_____
What do you do for exercise? _____
How many hours per week? _____
Do you follow a particular diet?_____
Gained or lost weight in the past 6 months? _____ How much?_____
Intentional?_____
Date of your last: Bone Density _____ Colonoscopy_____ Full Physical _____
Chest X Ray _____ EKG_____

List any medications (including vitamins) **and** doses you are taking: **(attachments here are welcome)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any allergies to any medications and your reaction to each:

_____ _____
_____ _____

List any medical conditions or illnesses

_____ _____
_____ _____
_____ _____

List all surgeries and dates of surgery

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY	IF LIVING: AGE & HEALTH PROBLEMS	IF DECEASED: AGE & CAUSE

FATHER _____

MOTHER _____

BROTHER _____

SISTER _____

SON _____

DAUGHTER _____

HUSBAND _____

WIFE _____

PLEASE LIST TWO OR THREE PEOPLE, INCLUDE THEIR PHONE NUMBER AND RELATIONSHIP TO YOU, FOR EMERGENCY CONTACT:

1) _____

2) _____

3) _____

PLEASE LIST ANY PERSON THAT IS WITH YOU AT YOUR APPT TODAY:

1) _____

2) _____

3) _____

A. IDENTIFICATION

Name (Last) (First) (Middle)

Maiden Name

Primary Address

City | State | Zip Code | Country

Alternate Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | E-mail Address

Date of Birth | Social Security Number

Height | Weight | Eye Color | Hair Color

Ethnicity/Race | Birthmarks/Scars

Blood/RH Type | Special Conditions | Marital Status

Occupation

Company Name

Address

City | State | Zip Code | Country

Phone Number | Languages Spoken - Primary and Secondary

Primary Health Insurance Carrier | Policy Number

Secondary Health Insurance Carrier | Policy Number

Spouse's Name

Occupation

Social Security Number | Date of Birth

B. EMERGENCY CONTACTS

In Case of Emergency, Notify: Primary Contact

Name (Last) (First) (Middle)

Relationship

Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | E-mail Address

In Case of Emergency, Notify: Secondary Contact

Name (Last) (First) (Middle)

Relationship

Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | E-mail Address

In Case of Emergency, Notify: Medical Contact

Physician (Indicate Specialty)

Phone

Dentist | Phone

Pharmacy | Phone

LIFETIME AUTHORIZATION

Insurance and/or Medicare certification for payment

I certify that the above information given by me in applying for payment under Title XIX of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediaries or carrier any information needed for this or related insurance claims. I request that the payment of authorize benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I authorize the release of any medical information necessary for insurance claim processing. I authorize payment of medical benefits of The Breast Clinic.

Signed: _____ Date: _____

By: _____ Relationship: _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

THE BREAST CLINIC

NOTICE OF PRIVACY PRACTICES

Effective Date: 4-14-2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, that is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAY WE USE AND DISCLOSE HEALTH INFORMATION.

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether you plan will cover it.

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, and off-site storage of medical records. When services such as these are contracted, we may disclose your health information to our business associated so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Communication with Family or Friends: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

We may also use and disclose medical information to/for the following:

*to remind you that you have an appointment
*to assess your satisfaction with our services
*Food and Drug Administration
*Organ and Tissue Donation Organizations
*Health Oversight Agencies
*Funeral Directors, Coroners, Medical Directors
*to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status
*Public Health Authorities
*Workers Compensation Agents
*Legal Authorities
*Military Command Authorities
*National Security & Intelligence Agencies
*Proactive Services for the President
*for law enforcement purposes as required by law or in response to subpoena.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for the copies.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at 850-862-3127.

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include this effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 850-863-2006. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will not longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of Notice of Privacy Practices,Office of **THE BREAST CLINIC**

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

PRINT Name _____ Signature _____ Date _____

Office Use Only:

Date Acknowledgement received _____ by _____

OR reason Acknowledgement was not obtained _____

I authorize The Breast Clinic to electronically obtain my medication history from my pharmacy.

Signature:_____

Date:_____