



Sharla Gayle Patterson, MD • Tam Mai, MD • Elizabeth Arguelles, MD
David Rock, MD • Steven Leibach, MD • Julianne Stewart, APRN

DATE: _____ PRIMARY DOCTOR: _____

NAME: _____ SSN: _____

SEX: Male Female AGE: _____ DATE OF BIRTH: _____

MARITAL STATUS: Single Married Divorced Widowed

LOCAL ADDRESS: _____ APT/UNIT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PREFERRED PHARMACY: _____

Pharmacy Name

Location

Phone

ALTERNATIVE ADDRESS: _____ APT/UNIT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT'S EMPLOYER: _____

(check one) Full Time Part Time Self Retired Unemployed

INSURANCE INFORMATION *Please provide all Insurance card(s) for our records*

PRIMARY INSURANCE/ID#: _____

POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INSURANCE/ID#: _____

POLICY HOLDER NAME: _____ DOB: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

PATIENT SIGNATURE: _____ **DATE:** _____



Date: _____

Your Full Name: _____ Age: _____

Date of Birth: _____

General:

Why are you seeing the doctor today? _____

Who is the referring doctor for this visit?: _____

Who is your Primary Care Physician?: _____

Weight: _____ Height: _____

Social History:

Do you use tobacco products? Yes No

If yes, how much per day? _____

Have you ever used tobacco products? Yes No

If yes, when did you quit (year) _____ and how many years did you smoke? _____

Breast Imaging History:

When was your last mammogram? _____

LOCATION of your last mammogram: _____

Medical History (continued)

Breast Health History:

Have you ever had a breast biopsy? Yes No

If yes, please list date and result of breast biopsy: _____

Have you ever had a breast MRI? Yes No

If yes, please list location, date, and result of MRI: _____

Have you ever had a biopsy showing atypical cells or LCIS? Yes No

Do you have breast implants currently? Yes No

Have you ever had breast implants? Yes No

If yes, please list date and type: _____

Have you had breast surgery? Yes No

If yes, please list date and type: _____

History of chest radiation? Yes No

Lymphoma treatment? Yes No

Bra cup size: _____

Gynecologic History:

Age at first menstrual period: _____ Age at last menstrual period: _____

Have you had a hysterectomy? Yes No

Have you had one or both ovaries removed? Yes No

Are you currently taking hormones? Yes No

If yes, when did you start taking them? _____

Have you taken hormones in the past? Yes No

If yes, when did you take them? _____

Are you pregnant today? Yes No Unsure

If ever pregnant, how old were you when your first baby was born?: _____

Medical History (continued)

Breast Cancer History *(Only answer these questions if you have ever been diagnosed or treated for breast cancer):*

When were you diagnosed with breast cancer? Year: _____ Age: _____

Which breast was diagnosed with breast cancer? Left: _____ Right: _____

Did you have surgery for your breast cancer? Yes No

If yes, was it? Lumpectomy -or- Mastectomy

Did you have reconstruction? Yes No

If yes, select one: Saline implants DIEP flap TRAM flap
 Silicone implants Latissimus flap

Did you have radiation for your breast cancer? Yes No

Did you have chemotherapy for your breast cancer? Yes No

Did you take medication for your breast cancer? Yes No

If yes, select one: Tamoxifen Arimidex Letrozole Femara Aromasin

Did you have genetic testing? Yes No

Did you have genetic counseling? Yes No

Medical History:

Have you been diagnosed or treated for any of the following?

- | | | | |
|---------------------|--|---------------------|--|
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Knee Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Breast Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Breast Reduction | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Heart Valve Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Other: _____ | |

Past Surgical History:

DATE	SURGERY	LOCATION	PROBLEM(s)

Family History of Cancer:

Are you of Ashkenazi Jewish ancestry? Yes No

Have you or your family members ever had genetic testing? Yes No

Have any of your family members been diagnosed with the following

	BREAST CANCER	OVARIAN CANCER	PANCREATIC CANCER	MELANOMA	COLON CANCER	OTHER CANCER	AGE OF DIAGNOSIS	STILL LIVING?
Mother								
Maternal Grandmother								
Maternal Grandfather								
Maternal Aunt								
Maternal Uncle								
Father								
Paternal Grandmother								
Paternal Grandfather								
Paternal Aunt								
Paternal Uncle								
Sibling								
Child								

Medications (Please list all medications that you are taking including supplements): _____

Please check the box of any of the following symptoms you may have experienced in the past 30 days:

Constitutional

- Fatigue
- Weight Loss

Eyes

- Vision changes
- Wear glasses/contacts

Ears, Nose, Mouth, Throat

- Voice changes
- Sore throat
- Nose bleeds

Skin

- Rash
- Itching

Genitourinary

- Burning with urination
- Post-menopausal

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea

Musculoskeletal

- Shoulder pain
- Back pain
- Joint pain or stiffness

Psychiatric

- Depression
- Anxiety

Endocrine

- Night sweats
- Cold or heat intolerance
- Frequent urination

Hematologic/Lymphatics/Immunologic

- Enlarged lymph nodes
- Easy bleeding or bruising

Cardiovascular

- Chest pain
- Chest pressure
- Chest discomfort

Neurologic

- Headaches
- Seizures

Respiratory

- Shortness of breath
- Cough
- Sputum



CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Date: _____

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Printed (patient or authorized representative)

Signature (patient or authorized representative)

Date

Valid for 1 year from date of signature



ASSIGNMENT OF BENEFITS

Date: _____

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, Unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Precision Healthcare Specialists, LLC** medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Precision Healthcare Specialists, LLC** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from **Precision Healthcare Specialists** on behalf of myself and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature (patient or authorized representative)

Date & Time

Witness Signature

Date



HIPAA PATIENT DISCLOSURE FORM FOR HEALTH INFORMATION

Date: _____

We understand that health information about you is personal, and we are committed to protecting your information. We create a record of the care and services you receive at **Precision Healthcare Specialists**. We need this record to provide care, for payment of care provided, for health care operations, and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

The Health Insurance Portability & Accountability Act of 1996 S160.103, also known as HIPAA, defines individual personal health information (PHI) as information, including demographic information collected from an individual and to include information that is:

- 1) Created or received by a health care provider, health plan, employer, or healthcare clearinghouse.
- 2) Related to the past, present or future physical, mental health and/or condition of an individual past, present or future payment for provision of health care to an individual.
- 3) The information, therefore, that identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.
- 4) Uses or disclosure to a personal representative assigned by patient.
- 5) Disclosure to the parents or persons acting in loco to parents to unemancipated minor.
- 6) For case management, care coordination for the individual, to direct or recommend alternative treatments or therapies, health care providers or health care selling.

The PHI can only be disclosed through a permitted disclosure (S164.502) and used by a health care provider in the following manners:

- For treatment: We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- For payment: We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment for your health plan to agree to pay for that treatment.
- For health care operations: We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance

HIPAA Patient Disclosure Form for Health Information (continued)

of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

I _____ am a patient of **Precision Healthcare Specialists, LLC** and understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time by myself. This disclosure becomes effective the date it is signed and will continue until it is cancelled, changed, altered, or amended by myself or my appointed legal representative. This facility has notified me that they have a listing of all the persons and agencies or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility.

I HAVE READ THE PERMITTED DISCLOSURE FORM AND I UNDERSTAND IT.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient Signature

Date & Time

Witness Signature

Date

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative

Legal Relationship

Date

Witness



TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT

Date: _____

Communication with our patients is a key aspect in providing high quality health care services. **Precision Healthcare Specialists** desire to communicate timely information regarding health care services to you in the most efficient means possible, including telephone and text messaging. Federal law requires that we obtain your consent prior to communicating with you via these means. Please read and sign below so that we can establish this communication process with you.

I _____ (*patient name*), authorize the use of my personal information, provider information, appointment information, and other limited information for the purpose of notifying me of any health care related function. I consent to receiving multiple messages from my health care provider, if needed, and I consent to allowing messages being left on my voicemail, answering system or with another individual, if I am unavailable at the number provided by me.

I also authorize any of **Precision Healthcare Specialists** independent contractors, agents and/or affiliates to contact me through the use of any equipment, an artificial voice or pre-recorded voice or other messaging system, at any telephone number associated with my account including cellular telephone numbers, provided by me or found even if I am charged for the call, as well as through any other personal contact information supplied by me. I understand that charges may apply to certain calls or text messages depending on my cellular plan.

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Precision Healthcare Specialists, LLC** medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Precision Healthcare Specialists, LLC** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from **Precision Healthcare Specialists** on behalf of myself and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature (patient or authorized representative)

Date & Time

Signature (Witness)

Date



RELEASE OF PATIENT INFORMATION TO INDIVIDUALS

Date: _____

At **Precision Healthcare Specialists**, we know that communication regarding your healthcare is important. By signing this form, you consent for us to discuss your healthcare with the individuals listed below and/or give us permission to leave messages.

I am aware that I can update or cancel this information at any time by notifying **Precision Healthcare Specialists'** staff.

I give consent for providers and staff to discuss medical, insurance, and billing information with the individuals below and I understand that proper judgement will be used when discussing such information.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

 Printed (patient or authorized representative)

 Printed (patient or authorized representative)

 Date & Time

 Relationship to Patient (if applicable)



RELEASE OF PATIENT INFORMATION

Date: _____

PATIENT NAME: _____ DOB: _____ PHONE NUMBER: _____

ADDRESS: _____
Street Address City State ZIP

1) I authorize the use or disclosure of the above-named individual's health information.

2) The following individual or organization is authorized to make the disclosure to
Precision Healthcare Specialists, LLC d/b/a Precision Breast Surgery:

****Please indicate provider info for us to obtain your records****

PROVIDER NAME: _____ PHONE: _____

ADDRESS: _____
Street Address City State ZIP

3) This disclosure may include:

- Laboratory reports and specimens, radiology reports and images (CT scans, ultrasounds, PET scans, etc.)
- Prescription records and drug information related to these records.
- Office notes, clinical chart reports, treatment plans, hospital records, discharge summaries and test results.

4) I understand that the information in my health records may include information related to behavioral or mental health services and treatment for alcohol and drug abuse. It may also include information about sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

5) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management team. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that the disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact a clinic representative at **Precision Breast Surgery**.

Signature of patient or legal representative

Printed of patient or legal representative

Date