Breast Surgical Services Medical Intake Form

David C. Weintritt, MD, FACS

MRN: _____

First Name (Please Print)_____Last Name:_____

Date of Birth:_____ Age: _____ Sex (circle one): M F

Race (optional): _____ Preferred language (optional): _____

Home phone: _____ Cell phone:_____

Work phone: _____ Email address: _____

Note: Your email address will only be used by the practice to notify you of specific reminders or how to access personal information. It will not be used for two-way communication regarding your medical care. Please contact our office if you have any questions or concerns related to your medical care.

Preferred method of contact (circle): Home phone Cell phone Work phone Email Mail

Emergency Contact Name: _____ Relationship: _____

Phone number: _____ Alternate phone: _____

Referring Physician First Name: _____ Last Name: _____

Referring Physician Address: _____

State: _____ Zip: _____ Phone: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____ City: _____ Zip code: _____

Pharmacy Phone: _____

Employer Name: _____ Employer Telephone: _____

Employer Address: _____ Occupation: _____

Full time ☐ Part Time ☐ Retired ☐ Unemployed ☐

Have you had a flu vaccine this flu season?: ☐ Y ☐ N

Have you had your COVID19 vaccination? ☐ Y ☐ N

Have you received any COVID boosters ? If so, how many _____

Sex (assigned at birth, check one) ☐ Male ☐ Female

Gender Identity_____ Sexual orientation_____

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Current breast problem or concern:

Symptoms	*Please mark as R (right), L(left), or B (both)*	*When did you first notice it, please explain?*
Pain?		
Lump or mass?		
Changes in the color or texture of the skin on your breast?		
Nipple discharge?		
Nipple inversion?		
Change in the shape or size of the breast?		
Swelling of axillary lymph nodes		

Additional symptoms:

Family history of Breast Cancer Y ☐ N ☐ Dense breast tissue Y ☐ N ☐

Do you perform self-breast exams? _____ How often? _____

Date of last mammogram? _____ Which facility? _____

Date of last ultrasound? _____ Which facility? _____

Are you currently breastfeeding or have you breastfed in the past 6 months? _____

Have you had breast problems in the past, Yes or No? _____ If yes, please explain in chart below.

Past Problems/Concerns	*Which breast?*	*Date?*	*Outcome/Treatment?*
Abnormal imaging			
Fine needle aspiration			
Biopsy, core or excisional			
Mastitis			
Abscess			

Have you had breast cancer in the past? _____ When? _____

Was your breast cancer invasive? _____ What surgery was performed? _____

Did you receive chemotherapy? _____Did you receive radiation therapy? _____

If you had radiation, was it whole breast or brachytherapy? _____

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Have you ever taken anti-hormone therapy (endocrine therapy)? _____ Which medication? _____

When? _____ How long did you take the medication? _____

Have you ever had genetic testing for breast or ovarian cancer? Result? _____

Has anyone in your family had genetic testing for breast or ovarian cancer? Result? _____

What age did you start your menstrual cycle? _____ Do you still have menstrual cycles? _____

First day of last cycle, or date of menopause? _____ How old were you for your first birth? _____

Have you had a hysterectomy? _____ If yes, were your ovaries removed? _____

Have you ever taken fertility drugs? _____ If yes, for how long? _____

Have you ever taken hormone replacement? _____If yes, over what age span? _____

Family history of cancer:

Are you adopted? _____ Are you of Ashkenazi decent? _____

Please list any first or second-degree relatives that have had ***breast, ovarian, colon, or pancreatic cancer***, and their age at diagnosis:

Relationship to you?	***Mother's or Father's side***	***Type of cancer?***	***Age at diagnosis***

Have you ever been diagnosed with any of the following problems?

- Asthma, COPD Please explain _____
- Kidney disease, Please explain _____
- Thyroid disease, Please explain _____
- Diabetes, Please explain _____
- Hypertension, Please explain _____
- Stroke, Please explain _____
- HIV/AIDS, Please explain _____
- Cancer, Please explain _____

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Social History:

Do you currently smoke? _____ How many cigarettes per day? _____ For how many years?_____

Are you a former smoker? _____ How many cigarettes per day? _____ For how many years? _____

Do you use caffeine? _____ What kind and how much? _____

Alcohol Intake? None Occasional Moderate Heavy Illicit drug use? _____

Past Surgical History: Please check if no prior surgeries ____

List all prior surgeries and the year they were performed

1. _____ Year? _____
2. _____ Year? _____
3. _____ Year? _____
4. _____ Year? _____
5. _____ Year? _____
6. _____ Year? _____

Current Medications: Please check if no current medications ____

1. _____ Dose? _____
2. _____ Dose? _____
3. _____ Dose? _____
4. _____ Dose? _____
5. _____ Dose? _____
6. _____ Dose? _____

Allergies: Please check if no current allergies ____

1. Medication _____Severity? _____ Reaction? _____
2. Medication _____Severity? _____ Reaction? _____
3. Medication _____Severity? _____ Reaction? _____
4. Medication _____Severity? _____ Reaction? _____
5. Medication _____Severity? _____ Reaction? _____
6. Other (latex, food) _____ Severity?_____ Reaction? _____

Height: _____ Weight: _____

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ADVANCE DIRECTIVE

Do you have an Advance Directive, also known as a Living Will? ☐ Y ☐ N

If yes, please provide us with a copy for your medical record when you are next in our offices.

If no, please consider completing an Advance Directive, as recommended for all adults regardless of health status. An advance Directive form is included in your new patient information packet.

If you were ever unable to speak for yourself, who would the doctors speak to on your behalf?

Name: _____ **Phone:** _____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Patient Name: _____ _____
Last First M.I. Today's Date

( ) _____ ( ) _____
Home Telephone Cell phone

Home Address: _____ Mailing Address: _____

_____ _____
City State Zip City State Zip

DOB: _____ Age _____ ☐ M ☐ F SS# _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Sex

Employer: _____ ( ) _____
Name Telephone

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Virginia Cancer Specialists, P.C. I also authorize agents of any hospital, treatment center or previous physician to furnish Virginia Cancer Specialists, P.C. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Virginia Cancer Specialists, P.C.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Virginia Cancer Specialists, P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Virginia Cancer Specialists, P.C.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (circle one)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (circle one)

PHYSICIAN _____
ACCT NBR _____ LOC _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

Virginia Cancer Specialists

PERMISSION FOR VERBAL COMMUNICATIONS

To protect the patient's privacy and to ensure that our clinic staff and physicians know whom they have permission to communicate with regarding the patient's protected health information, it is helpful for patients to have a Permission for Verbal Communications form on file at Virginia Cancer Specialists.

_____

Patient's Name

I permit Virginia Cancer Specialists to discuss health information with the following individuals involved in my medical care or payment of my care:

List individuals and state the person's relationship to the patient.

Name	Phone Number	Relationship
1.		
2.		
3.		

****

This authorization is limited to discussions regarding the following medical condition(s):

_____

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

****

This authorization is limited to the following timeframe from

_____ (date) to _____ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

_____

Patient's Signature **Date**

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____

Name of Personal Representative **Relationship to Patient**

_____

Witness **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Virginia Cancer Specialists, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Virginia Cancer Specialists.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Virginia Cancer Specialists Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained and employee signature:

_____

_____

_____

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Witness **Date**

Virginia Cancer Specialists

PATIENT CONSENT FORM - 3rd PARTY API

A new option for you to view your health information

What is a 3rd Party API?

An application you can access using a computer, phone or tablet to view the health information in your chart. Depending on the type of app, you will be able to view information such as diagnoses, lab results and medication lists. Apps may offer different features, so you can pick what best meets your needs.

Why?

New Medicare requirement to give patients the option to view their information using a 3rd Party Application. This is in addition to our patient portal, My Care Plus.

How?

- Complete consent for 3rd party API.
- Request a registration access code from our office. *(**Codes expire after 7 days.)*
- Access the iKnowMed API Portal website to enter your code and create an account. https://apiaccess.mckesson.com
- You will need to use Chrome to access the iKnowMed API Portal.
- Applications that meet the iKnowMed security and technical requirements will be listed.
- You may select any applications from the list, and depending on the application, access them from a computer, phone or tablet.

Registration is open for patients as of 9/3/18, as 3rd party applications become available they will be added the website.

By signing below, I hereby consent to use of the 3rd party API technology. At any point in time, it is my right to decline the use of 3rd party API.

_____ _____ _____

Patient's Name (PRINT) Patient's DOB IKM ID

_____ _____

Patient's Signature Date

_____ _____

Signature of Practice Staff Date

[Confirming user's identity and authority]

Staff: Complete consent process in IKM then scan document.