Breast Surgical Services Medical Intake Form

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 ☐

Today's date: _____

Reason for Visit: _____

Do you have any particular concerns about your breast health? _____

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Medical History:

Do you have a history of:

	Yes	No		Yes	No		Yes	No
Heart Attack?			Kidney Problems?			Hepatitis?		
Stroke?			Liver Problems?			HIV/AIDS?		
High Blood Pressure?			Seizures?			TB?		
Diabetes?			Psychiatric disorder?			Radiation Therapy?		
Asthma?			Anemia?			Other Medical Problems?		
Lung Disease?			Bleeding Disorder?					
Sleep Apnea?			Cancer?					

Previous Surgeries:

Previous Hospitalizations:

Allergies:

Do you have any drug Allergies? ☐ No ☐ Yes If yes, please list your allergies & describe your reaction

Current Medications

Medication	Dose	How many times per day?	Reason for taking

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Gynecologic history:

Age at first period: _____ LMP: _____ Age of menopause: _____
Total # of pregnancies_____ Total # of births_____
How old were you when you had your first baby? _____
Bra size_____

Date of most recent mammogram? _____
Have you experienced:
Nipple discharge: Y N
Breast Pain: Y N

Have you ever used:
Birth Control Pills Y N If Yes, # of Years used : _____
Hormone Replacement or Fertility Drugs: Y N
Did you Breast Feed: Y N

Other Breast History:_____

Family History:

Have any of your **relatives** ever had:

			Who?	at what age?
Breast cancer?	N	Y	_____	
			_____	
			_____	
Ovarian cancer?	N	Y	_____	
			_____	
			Who?	What kind of Cancer?
Any other cancer?	N	Y	_____	
			_____	
			_____	

What is your Ethnic Background? _____

Social History:

Marital Status: S M D W
Occupation: _____
Do you drink alcohol? □ No □Yes (how often?_____)
Do you smoke? □ Never □ Previously, but quit (when?_____)
□ Yes, currently (how many years?_____)
Do you use recreational drugs? □No □Yes (describe:_____)

Have you had a flu vaccine this flu season?: ☐ Y ☐ N If so, when? _____

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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Review of Systems:

Please circle any health problems in the following areas:

CONSTITUTIONAL	HEENT	CARDIOVASCULAR	RESPIRATORY
Fever Chills Night Sweats Fatigue Weight change	Vision problems glasses / contacts Double vision Cataracts Glaucoma Hearing problems Ringing in ears Sinus pain Congestion Sore throat Dental problems Difficulty swallowing Pain with swallowing Hoarseness	Chest pain Palpitations Heart murmur Edema Pain with walking Pain in legs at rest	Cough Sputum (bloody?) Difficulty breathing Pain with breathing Wheezing Snoring
GASTROINTESTINAL	**GENITOURINARY**	**MUSCULOSKELETAL**	**SKIN**
Poor appetite Heartburn Regurgitation Nausea Vomiting Abdominal pain Diarrhea Constipation Bloody stool	Urinary pain Urinary urgency Urinary incontinence Blood in urine	Muscle aches Swelling Joint pain Bone pain Weakness	Rash Itchiness Dryness Moles or skin lesions Nail changes
NEUROLOGIC	**PSYCHIATRIC**	**ENDOCRINE**	**HEMATOLOGIC**
Headache Seizures Numbness Tingling Dizziness Tremor Decreased coordination Memory loss Confusion	Anxiety Depression Sadness Hopelessness	Heat or cold intolerance High blood sugar Thyroid problems Hair loss	Easy bruising/bleeding Sickle cell disease Thalassemia History of blood transfusion Lymph node problems
GYNECOLOGIC	**BREAST**	**OTHER**	
Vaginal bleeding Vaginal discharge Pelvic pain	Breast pain Breast mass Nipple discharge		

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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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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.