The Comprehensive Breast Care Center of Tampa Bay

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Thank you for choosing The Comprehensive Breast Care Center of Tampa Bay.

Appointment Location

___ Axelrod Pavilion
400 Pinellas Street
Suite 200
Clearwater, Florida 33756
(727) 462-2131

Appointment Date: __________________

Please arrive at: _________:________am/pm

___ Morton Plant Mease Outpatient Center
2102 Trinity Oaks Boulevard
Suite 202
Trinity, FL 34655
(727) 462-2131

Please bring the following information to the appointment with you:

Photo ID

Insurance Card(s)

Completed paperwork

Disks and reports from imaging center outside of Morton Plant (example: SDI, Rose Radiology, Gateway Radiology, Palm Harbor MRI, Westcoast Radiology)

Failure to bring completed paperwork and imaging reports/disks may result in your appointment being rescheduled.

Thank You!

The Comprehensive Breast Care Center of Tampa Bay

Patient Registration Form

Patient Information

Name: ______________________ Preferred first name: ______________________

DOB: ______________________ ❑ Female ❑ Male SSN: ______________________

Primary phone: ______________ Type: ❑ Home ❑ Cell ❑ Work Marital status: ______________

Primary patient notification preference: ❑ Primary phone ❑ Secondary phone ❑ Mail

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Primary language: ______________________

Primary address: ______________________

City: ______________________ State: ____________ Zip: ____________

Country of primary address: ______________________

Secondary phone: ______________________ Type: ❑ Home ❑ Cell ❑ Work

Personal email*: ______________________ Preferred method of notification: ❑ Phone ❑ Email

**Personal email is required for access to the patient portal*

Secondary address: ______________________

City: ______________________ State: ____________ Zip: ____________

Additional Patient Information

Primary care physician: ______________________

Person financially responsible: ______________________ Relationship: ______________________

Referring physician (if different from primary care): ______________________

How did you hear about us? ______________________

Employer: ______________________

Employer address: ______________________

City: ______________________ State: ____________ Zip: ____________

Phone: ______________________ Ext: ____________

Emergency contact: ______________________ Emergency contact: ______________________

Relationship to contact: ______________________ Relationship to contact: ______________________

Contact phone: ______________________ Contact phone: ______________________

Employment status: ______________________

Patient Registration Form

Insurance Information

Primary: ______________________ Secondary: ______________________

Policy holder ID: ______________________ Policy holder ID: ______________________

Policy holder name: ______________________ Policy holder name: ______________________

Policy holder DOB: ______________________ Policy holder DOB: ______________________

Policy holder's employer: ______________________ Policy holder's employer: ______________________

Patient relationship to policy holder: ______________________ Patient relationship to policy holder: ______________________

Policy holder sex: ☐ Female ☐ Male Policy holder sex: ☐ Female ☐ Male

Copay amount: ______________________

Pharmacy: ______________________ Location: ______________________

Pharmacy phone: ______________________

Extended Information

Do you have a visual impairment that will prevent you from reading written material from your doctor? ☐ Yes ☐ No

Do you have a hearing impairment that will complicate spoken communication with your doctor? ☐ Yes ☐ No

Have you seen a specialist since your last visit with your primary care doctor? ☐ Yes ☐ No

If yes, please indicate the name of the provider(s) below.

Provider: ______________________

Provider: ______________________

Patient signature: ______________________

Date: ___/___/___

Printed name: ______________________

Health Information Questionnaire

Name: ______________________________ Date: ___/___/___

DOB: ______________________ Age: ________ ❑ New patient ❑ Established patient

What medical/health concerns bring you to our office today? ______________________________

____

Medical History

Have you ever had or been diagnosed to have (check all that apply):

- ❑ Alzheimer's disease
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Bleeding disorder
- ❑ Blood transfusion
- ❑ Cancer: What kind? ______________
- ❑ Cataracts
- ❑ Chicken pox
- ❑ Colon polyps
- ❑ Depression
- ❑ Diabetes/prediabetes
- ❑ Fracture
- ❑ Glaucoma
- ❑ Heart attack
- ❑ Heart disease
- ❑ Heart failure
- ❑ Heart murmur
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irritable bowel syndrome
- ❑ Jaundice/liver disease
- ❑ Kidney disease
- ❑ Migraines/headache
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Prostate problems
- ❑ Rheumatic fever
- ❑ Seizures/epilepsy
- ❑ Stroke
- ❑ Syphilis
- ❑ TB/lung disease
- ❑ Thyroid disease
- ❑ Ulcers
- ❑ Urinary incontinence
- ❑ Other: ____________

OB/GYN History (females only):

Age of menses: _____ Age of menopause: _____ Method of birth control: ______________

How many pregnancies: _____ How many children: ________ Vaginal or C-section ____________

Hospitalizations and Surgeries

List any hospitalizations, surgeries or procedures you have had performed.

What	Date	What	Date

Specialists

List any other doctors involved in your care.

Name	Specialty

BayCare Medical Group

Health Information Questionnaire

Medications

List all medications you take on regular basis (include over-the-counter, herbal or natural remedies).

Medication Name	Strength	Daily Frequency	Medication Name	Strength	Daily Frequency

Allergies

Are you allergic to any medications? ❑ Yes ❑ No

If yes, please list: ______________________________

Health Maintenance

If you've had a test or vaccine done, list when last performed:

❑ Bone density test: ______________
❑ Cholesterol screen: ______________
❑ Colonoscopy: ______________
❑ Diabetes screen: ______________
❑ Eye exam: ______________
❑ Flu vaccine: ______________
❑ Hep A vaccine: ______________
❑ Hep B vaccine: ______________
❑ HIV testing: ______________
❑ HPV vaccine: ______________
❑ Mammogram (females only): ________
❑ Meningococcal vaccine: ________
❑ Pap smear (females only): ________
❑ Pneumonia vaccine: ______________
❑ Shingles vaccine: ______________
❑ Tetanus vaccine: ______________

Family History

Please indicate if your blood relative(s) have had/currently have the following by placing an X in appropriate column:

Family Member	Alcoholism	Mental Health Issues	Heart Attack/Disease	High cholesterol	High Blood Pressure	Diabetes	Thyroid Disease	History of Bowel Problems	Allergies	Osteoporosis	Alzheimer's Disease	Seizure	Stroke	Cancer (what kind)	Other
Mother (age __)															
Father (age __)															
Brother(s) (age __)															
Sister(s) (age __)															
Grandparents															
Biological children															
Other: __________															

New Patient Health Questionnaire

Social History

Do you drink alcohol? ❑ Yes ❑ No
If you answered yes, answer these additional questions:
- What type of alcohol? ______
- How frequently? ______
- How many drinks does it take to get you high? ______
- Have people annoyed you by criticizing your drinking? ❑ Yes ❑ No
- Have you ever felt you should cut down on your drinking? ❑ Yes ❑ No
- Have you ever had a drink first thing in the morning to steady your nerves? ❑ Yes ❑ No

- Have you ever had a substance abuse problem? ❑ Yes ❑ No

If you answered yes, answer these additional questions:
- What type of drugs do you use? ______
- How frequently? ______

Have you ever smoked? ❑ Yes ❑ No
If you answered yes, answer these additional questions:
- Do you still smoke? ❑ Yes ❑ No
- How many cigarettes/day? ______
- How many years have you smoked? ______
- If you recently stopped smoking, when did you quit? ______

Occupation: ______ ❑ Full-time ❑ Part-time
If retired, what was your former occupation: ______

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: ______

Education through grade: ______

Do you regularly exercise? ❑ Yes ❑ No
What type of exercise (e.g. biking, walking, running, swimming, etc.)? ______ How often? ______

Number of children: ______ Number of persons in household: ______
What type of living arrangement: ❑ House ❑ Apartment ❑ Condo ❑ Dorm ❑ Other: ______
Do you feel safe in your home environment? ❑ Yes ❑ No

Do you eat a healthy diet? ❑ Yes ❑ No
Are you on a special diet? ❑ Yes ❑ No
Do you use caffeine on regular basis? ❑ Yes ❑ No
Do you have any sleeping problems? ❑ Yes ❑ No
Do you have a high level of stress in your life? ❑ Yes ❑ No
Do you lack interest or pleasure in doing things you used to do? ❑ Yes ❑ No
Are you sexually active? ❑ Yes ❑ No
First active at age: ______ Current # of partners: ______ Number of life partners: ______
Self-described orientation: ______
Use of contraception: ❑ Condoms ❑ Birth control ❑ Other: ______

New Patient Health Questionnaire

General Information

Who completed this health form? ______________________________

What is your preferred language for health care information? ______________________________

What is the best way for the office to contact you? ❑ Phone ❑ Email ❑ Other: ______________

Are you disabled? ❑ Yes ❑ No

If yes, what is the nature of your disability? ______________________________

Do you have a living will or an advance directive? ❑ Yes ❑ No

If yes, what type? ______________________________

If you experienced any of these issues in the last 10 days, place a check mark next to the symptom.

General
- ❑ Recent fever
- ❑ Excessive fatigue
- ❑ Unexplained weight loss/gain

Eyes
- ❑ Discharge
- ❑ Pain or burning
- ❑ Blurred vision
- ❑ Loss of sight
- ❑ Itching or watering

Breast
- ❑ Pain
- ❑ Lumps
- ❑ Nipple discharge

Respiratory
- ❑ Cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Snoring

Reproductive - Women
- ❑ Irregular periods
- ❑ Spotting between periods
- ❑ Vaginal discharge/ burning/itching
- ❑ Unusually painful periods
- ❑ Pain/trouble during intercourse

Reproductive - Men
- ❑ Discharge from penis
- ❑ Pain or swelling of testicles
- ❑ Pain/trouble during intercourse
- ❑ Problems with erection

Mental Health
- ❑ Thoughts of suicide
- ❑ Marital problems
- ❑ Trouble sleeping
- ❑ Panic attacks
- ❑ Anxiety
- ❑ Thoughts of harming others

Skin
- ❑ Change in nails
- ❑ Lumps
- ❑ Recurrent rashes
- ❑ Sores that will not heal or that bleed
- ❑ Moles that are changing

Ears
- ❑ Hearing loss
- ❑ Ringing
- ❑ Earache
- ❑ Feeling of ear fullness

Mouth and Throat
- ❑ Dry mouth
- ❑ Soreness or bleeding in mouth area
- ❑ Sore throat
- ❑ Mouth ulcers
- ❑ Hoarseness
- ❑ Dental issues

Endocrine
- ❑ Unusual intolerance of heat
- ❑ Unusual intolerance of cold
- ❑ Excessive thirst
- ❑ Excessive hunger

Urinary
- ❑ Pain/burning with urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Trouble starting to urinate
- ❑ Waking up to urinate
- ❑ Leakage of urine
- ❑ Change in stream

Nervous System
- ❑ Headaches
- ❑ Seizures/convulsions
- ❑ Fainting spells
- ❑ Frequent memory loss
- ❑ Weakness
- ❑ Shakiness or tremor
- ❑ Loss of sensation/numbness
- ❑ Feeling of tingling in limb
- ❑ Speech difficulty

Nose and Sinuses
- ❑ Bleeding
- ❑ Nasal congestion
- ❑ Sneezing
- ❑ Loss of sense of smell

Neck
- ❑ Pain
- ❑ Lumps

Cardiovascular
- ❑ Abnormal/irregular heart beat
- ❑ Chest pain
- ❑ Awaken at night with breathing problems
- ❑ Passing out
- ❑ Shortness of breath
- ❑ Swelling of ankles
- ❑ Leg pain/resting
- ❑ Leg pain/walking

Gastrointestinal
- ❑ Unable to eat certain foods
- ❑ Loss of appetite/weight
- ❑ Food sticks in throat
- ❑ Painful swallowing
- ❑ Heartburn
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal or stomach pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Recent change in bowel habits
- ❑ Blood in stools
- ❑ Black stools

Musculoskeletal
- ❑ Joint pain
- ❑ Joint stiffness
- ❑ Muscle soreness

Blood Disorders
- ❑ Easy bruising
- ❑ Excessive bleeding

Family History Questionnaire

Name ______________________________ DOB ____________ Date____________

Please complete the following personal and family history to better assess your breast cancer risk

Family	Deceased Y/N	Age of Diagnosis	Breast	Ovary	Pancreas	Uterus	Colon Rectum	Stomach or Small Bowel	Melanoma	Thyroid	Other
You	N/A										
Your Daughter											
Your Son											
Your Mother											
Your Father											
Your Sister(s)											
Your Brother(s)											
Maternal Grandmother											
Maternal Grandfather											
Maternal Aunt(s)											
Maternal Uncle(s)											
Paternal Grandmother											
Paternal Grandfather											
Paternal Aunt(s)											
Paternal Uncle(s)											
Other											

Have you or any family member ever had genetic testing? ❑ Yes ❑ No If yes, please list type and results:

____

Are you of Ashkenazi ancestry? ❑ Yes ❑ No ❑ Unknown

Office Use Only:
Outcome: Genetic Testing/Counseling Offered/Refused Initials ________ Date ________

Breast Care Health Questionnaire

Name: ______________________________ DOB: ___/___/___ Date: ___/___/____

PREGNANCY:

Age of first live birth: ________

Number of living children: ______

Did you breastfeed: ❑ Yes ❑ No

If you are of childbearing age (or pre-menopausal), do you plan on having additional children? : ❑ Yes ❑ No

MENSTRUAL PERIODS:

Age of your first menstrual period: ______

Are your periods regular? ❑ Yes ❑ No

Date last period began? __________

Age at menopause? __________

BIRTH CONTROL:

Have you ever taken birth control pills? ❑ Yes ❑ No

When and for how long? __________

HORMONE THERAPY:

Have you ever taken hormones? ❑ Yes ❑ No

What drug: ________________

(e.g. Premarin/Prempro/Bioidenticals)

When and for how long? ____________

SURGICAL HISTORY:

Hysterectomy	❑Yes ❑ No	Date: __________ Age: ________
Ovaries Removed	❑Yes ❑ No	Right / Left/ Both Date: ________ Age: ________
Breast Biopsy	❑Yes ❑ No	Right / Left Date: __________ Age: ________
Previous Chest Wall Radiation	❑Yes ❑ No	If so, when and where? ______________

CURRENT PROBLEM:

Lump you can feel	❑Yes ❑ No	**When did you first notice?**
Pain	❑Yes ❑ No	______________
Nipple Discharge	❑Yes ❑ No	______________
Breast Trauma	❑Yes ❑ No	______________
Abnormal Mammogram	❑Yes ❑ No	______________
Abnormal Ultrasound	❑Yes ❑ No	______________
Other	❑Yes ❑ No	______________

IMAGING:

When and where was your last mammogram? ______________________

When and where was your last breast ultrasound? ______________________

When and where was your last bone density? ______________________

PHYSICIAN NOTES:

____

____

____

____

____

____

Uses and Disclosures of Your Protected Health Information (PHI)

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures.

Tell us with whom we may discuss your protected health information: (Name and relation - Example: Jane Doe, Wife; Jan Doe, Daughter) ______________________________

Messages or Appointment Reminders

Messages will be of a non-sensitive nature, such as, appointment reminders.

May we leave a message on your voice mail using doctor's/practice name? ❑ Yes ❑ No

May we leave a message with another individual using doctor's/practice name? ❑ Yes ❑ No

May we leave a message at your work using doctor's/practice name? ❑ Yes ❑ No

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

______________________________ ______________________________

Patient/guardian signature Date

____

Print name of person signing

If other than the patient (patient name) ______________________________

is signing, are you the legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or health care operations? ❑ Yes ❑ No

Patient Consent

Request for Care and Consent for Treatment

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered to the patient under the general and special instructions of the patient's physician. BayCare Medical Group has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Assignment of Insurance Benefits

I authorize payment directly to BayCare Medical Group of any insurance benefits otherwise payable to me for services, at a rate not to exceed BayCare Medical Group regular charges for such services.

Releasing Medical Information

I understand that BayCare Medical Group, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal health care operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Facility and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review BayCare Medical Group's Notice of Privacy Practices.

Permission for Treatment

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below such medical and surgical treatment as is deemed necessary.

The undersigned certifies that he/she has read the forgoing, received a copy therof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Patient (print name): ____

Signature of patient or authorized person: ____

Relationship: ______________________________ Date: ______________

Witness signature: ______________________________ Date: ______________

If the patient did not sign, please state reason: ____

Financial Responsibility

Important Information Regarding Your Account

Statement of Financial Responsibility
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services
I am aware that some services performed by the Practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses *(For patients with "Out-of-Network" coverage)*
I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill To/Payment Instructions

_____ Commercial Insurance/Third Party Payor _____ Medicare _____ Medigap*
Initial Initial Initial

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to be made to the Practice on my behalf.

*If Medigap________________________ ________________________ ________________________
Name of Beneficiary Medigap Policy Number Health Insurance Claim Number

List Names of Those with Whom You Want Us to Share Your Financial Responsibility Information:

Name:	Relationship:

Financial Agreement
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Patient's name: ____
(please print)

Patient (or legal guardian's) signature: ________________________

Date: ________________________

If legal guardian, relationship to the patient: ________________________

Authorization to Use or Disclose Protected Health Information

☐ Physician______________________________

I hereby authorize the above physician(s) to use or disclose the following information from the health records of the individual whose name is described below.

Patient Name:______________________________ Date of Birth:______________
(Please Print)

Address:____
(City) (State) (Zip)

Phone Number:____________________ Social Security #____________________

I authorize the above physician(s) to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name:____

Address:____
(City) (State) (Zip)

- This information for which I'm authorizing disclosure will be used for the following purpose:

Description:____

Dates of service to be released:______________________________________

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated). **Copy medical records to ☐ Electronic medium or ☐ Paper**

☐ Office Notes
☐ Immunization Record
☐ EKG
☐ Radiology Results
☐ Lab Results
☐ Medications
☐ Other: (please describe)______________________________________

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

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 department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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.

Signed______________________________ Date______________
Patient or Authorized Person, ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney
☐ Photo ID checked

Witness:______________________________ Date:______________

Copied by:____________________ Date:______________ Pages copied:__________

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION BC 2958 4/16	P A T I E N T