# Comprehensive Breast Center of Arizona

## Patient Information

***PATIENT DEMOGRAPHICS***

Last Name:_____First Name:_____MI:_____

Date of Birth:_____ Social Security:_____

***CONTACT***

Home:_____ Work:_____ Cell:_____

May we leave a detailed message? _____YES _____NO If yes, please circle preferred number.

Email:_____

***ADDRESS***

Address:_____

City:_____ State:_____ Zip:_____

***EMERGENCY CONTACT***

Last Name:_____ First Name:_____

Phone Number:_____ Relationship to Patient:_____

***INSURANCE/POLICY HOLDER***

Plan Name:_____ ID Number:_____

Subscriber Last Name:_____ First Name_____

Date of Birth: _____ Relationship to Patient:_____

***PRIMARY PHYSICIAN***

Physician Name: _____ Physician Phone:_____

***REFERRING PHYSICIAN***

Physician Name:_____ Physician Phone:_____

***PREFERRED PHARMACY***

Pharmacy Name:_____Cross Streets:_____

Pharmacy City:_____Pharmacy Phone:_____

***SIGNATURE (All information is correct)***

Name:_____Date:_____

# Comprehensive Breast Center - Medical History Form

Name:_____ Date of Birth:_____

| **PAST MEDICAL HISTORY (**Please darken **Yes** response bubble completely) | | | | | |
|---|---|---|---|---|---|
| Acute Myocardial Infarction (Heart Attack) | O Yes | O No | Myocardial Infarction | O Yes | O No |
| Atrial Fibrillation (Irregular Heartbeat) | O Yes | O No | Multiple Sclerosis | O Yes | O No |
| Carotid Stenosis (Blockage in Neck) | O Yes | O No | Obesity | O Yes | O No |
| Cardiomyopathy (Enlarged Heart) | O Yes | O No | Ovarian Mass | O Yes | O No |
| Asthma | O Yes | O No | Parkinson's Disease | O Yes | O No |
| Anxiety | O Yes | O No | Renal Insufficiency, Chronic Kidney | O Yes | O No |
| Blood Dyscrasias (Blood Clotting Disorder) | O Yes | O No | Rheumatic Heart Disease | O Yes | O No |
| Cirrhosis | O Yes | O No | Sleep Apnea | O Yes | O No |
| Diabetes Mellitus | O Yes | O No | Seizures | O Yes | O No |
| Emphysema | O Yes | O No | Stroke | O Yes | O No |
| Family History of Colon Cancer | O Yes | O No | Cancer, Breast | O Yes | O No |
| Family History of Coronary Artery Disease | O Yes | O No | Cancer, Colon | O Yes | O No |
| Heart Murmur (Mitral Valve Prolapse) | O Yes | O No | Cancer, Lung | O Yes | O No |
| Hypercholesterolemia (High Cholesterol) | O Yes | O No | Cancer, Melanoma | O Yes | O No |
| Hypertension | O Yes | O No | Cancer, Lymphoma | O Yes | O No |
| Hepatitis C | O Yes | O No | Cancer, Ovarian | O Yes | O No |
| Hyperthyroidism (High Thyroid) | O Yes | O No | Cancer, Renal Cell | O Yes | O No |
| Hypothyroidism (LowThyroid) | O Yes | O No | Cancer, Skin | O Yes | O No |
| HIV Positive | O Yes | O No | Cancer, Stomach | O Yes | O No |
| | | | Cancer, Thyroid | O Yes | O No |
| **SURGICAL HISTORY** | | | | | |
| Appendectomy (Appendix Removed | O Yes | O No | Breast Biopsy | O Yes | O No |
| Cholecystectomy (Gallbladder Removed | O Yes | O No | Lumpectomy | O Yes | O No |
| Aortic Valve Replacement | O Yes | O No | Breast Implant | O Yes | O No |
| Coronary Artery Bypass Graft | O Yes | O No | Breast Reconstruction | O Yes | O No |
| Aortobifemoral Bypass | O Yes | O No | Lymph Node Resection | O Yes | O No |
| Carotid Endarterectomy | O Yes | O No | Mastectomy (Breast Removed) | O Yes | O No |
| Pacemaker, Cardiac | O Yes | O No | Nephrectomy (Kidney Removed) | O Yes | O No |
| Lung Resection | O Yes | O No | Thyroidectomy (Thyroid Removed) | O Yes | O No |
| Bladder Surgery | O Yes | O No | Transplant, Kidney | O Yes | O No |
| Brain Aneurysm | O Yes | O No | Hysterectomy, Partial | O Yes | O No |
| | | | Hysterectomy, Total with Bilateral Salpingo-Oophorectomy (BSO) | O Yes | O No |

# Comprehensive Breast Center – Medical History Form

Name:_____ Date of Birth:_____

| General/Constitutional | | | Breast | | |
|---|---|---|---|---|---|
| Bone Pain | O Yes | O No | Bloody Nipple Discharge | O Yes | O No |
| Fatigue | O Yes | O No | Breast Lump | O Yes | O No |
| Fever | O Yes | O No | Breast Pain | O Yes | O No |
| Night Sweats | O Yes | O No | Breast Swelling | O Yes | O No |
| New Onset Headache | O Yes | O No | Cracked Nipple | O Yes | O No |
| **Gastrointestinal** | | | Nipple Discharge | O Yes | O No |
| Blood in Stool | O Yes | O No | Nipple Retraction | O Yes | O No |
| **Ophthalmologic** | | | Red Skin | O Yes | O No |
| Blurred Vision | O Yes | O No | Skin Dimpling | O Yes | O No |
| **Neurologic** | | | **Hematology** | | |
| Dizziness | O Yes | O No | Easy Bruising | O Yes | O No |
| Tingling/Numbness | O Yes | O No | HIV | O Yes | O No |
| Difficulty Speaking | O Yes | O No | Prolonged Bleeding | O Yes | O No |
| Seizures | O Yes | O No | Recent Transfusion | O Yes | O No |
| Fainting | O Yes | O No | Weakness | O Yes | O No |
| **Cardiovascular** | | | **Respiratory** | | |
| Heart Attack | O Yes | O No | Blood in Sputum | O Yes | O No |
| Heart Murmur | O Yes | O No | Cough | O Yes | O No |
| Swelling in Legs | O Yes | O No | Shortness of Breath at Rest | O Yes | O No |
| Chest Pain at Rest | O Yes | O No | Shortness of Breath with Exertion | O Yes | O No |
| Chest Pain with Exertion | O Yes | O No | Wheezing | O Yes | O No |
| Irregular Heartbeat | O Yes | O No | **Social History** | | |
| | | | Tobacco Use | O Yes | O No |

# Comprehensive Breast Center – Medical History Form

Name:_____ Date of Birth:_____

| OB/GYN History | |
|---|---|
| How old were you when you started your period? | |
| How old were you when you experienced menopause? | |
| How old were you with your first pregnancy? | |
| How many pregnancies have you had? | |
| How many live births? | |
| If you have taken oral contraceptives, how many years did you use them? | |
| If you have taken fertility treatments, how many years did you use them? | |
| If you have used hormone replacement therapy (estrogen), how many years? | |
| **Social History** | |
| How much caffeine do you drink? | |
| How much alcohol do you consume a week? | |
| How many cigarettes do you smoke a week? | |
| **Family History** | |
| Who in your family has had breast cancer? | |
| Who in your family has had ovarian cancer? | |
| Are you an Ashkenazi Jewish? | O Yes O No |
| **We ask since this subgroup has higher incidence of getting breast cancer** | |
| **Allergies** | |
| What medications are you allergic to? | None____Penicillin____Sulfa____Other: |
| **Current Medications with Dosages** | |
| | |
| Any other relevant medical, surgical, social, or family history not listed above? | |

# Comprehensive Breast Center of Arizona

**Films**

I understand that **Comprehensive Breast Center of Arizona** is not responsible for any films. They do not store films in this office. Do not have films mailed or dropped off at this site. **Please hand-carry your films to your appointment. Do not have films couriered to this office, as this service can be unreliable.** I will be responsible for returning my films to the original radiology facility.

**Assignment of Benefits Form**

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 me and/or my department regardless of my insurance benefits. I understand that I am responsible for any amount not covered by my insurance.

**Authorization to Release Information**

I authorize Dr. Gunia/Dr. Liu to release any information necessary to insurance carriers regarding my illness and treatment: (2) process insurance claims generated in the course of treatment (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

**Patient Acknowledgement of HIPAA Notice**

I understand that my/the patient's health information is private and confidential. I understand that the **Comprehensive Breast Center of Arizona** works hard to protect my/the patient's privacy and preserve the confidentiality of my health information.

I understand that the **Comprehensive Breast Center of Arizona** may use and disclose the patient's health information to provide treatment to me, to handle billing and payment and to take care of other healthcare operations. In general, there will be no other uses and discloses of this information unless I permit it. **Comprehensive Breast Center of Arizona** contains detailed information about how they may use and disclose patient health information and I acknowledge that I can receive a copy of this "Notice" for my own records.

**Comprehensive Breast Center of Arizona** may update the "Notice of Privacy Practices." If I ask, I will be provided with the most current "Notice of Privacy Practices." My signature below indicates that a current copy of **Comprehensive Breast Center of Arizona's** "Notice of Privacy Practices" has been made available to me.

Patient/Legally Authorized Signature Date/Time

I give permission to **Comprehensive Breast Center of Arizona** to release my health information to the following person(s)_____

_____

_____

# Comprehensive Breast Center of Arizona

Thank you for choosing the **Comprehensive Breast Center of Arizona**. We welcome you to our practice. We are committed to providing the finest personalized and professional care. ***Please carefully read and sign the following statement of our financial policy prior to treatment***.

The patient or the guarantor is responsible for payment of services that are rendered if we are a preferred provider on your insurance plan. We will submit claims to your insurance company and make every attempt to collect with the information that you provide. ***Please present your insurance card at each visit. You will be responsible for all co-pays, coinsurance, and deductibles on the day of service***.

*IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS BEFORE THE VISIT. All insurance information including prior authorizations must be provided at the time of service and before you are seen. It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.*

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. Upon review of your account at 60 days past your original bill submission date the balance of your account now falls to your full financial responsibility. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of your coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. We accept cash, checks, debit cards, VISA, and MasterCard. There will be a $30.00 service charge for returned checks.

Delinquent accounts over 90 days will be placed for collections with a third party collection agency, and a fee for 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed, such as court costs, attorney fee, and all other expenses.

I have read and understand the Financial Policy and agree to abide by the terms.

_____

PRINTED NAME

_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

_____

Address

_____

Phone Number

_____ _____

Email Address Pharmacy with City/State