THE *Breast* CENTER
AT SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

IMPORTANT
Patient Instructions

1. Please fill out all sections of enclosed forms completely.

(a) It is very important that we have your complete medical history. Please include all medications and dosages. (Vitamins as well)

(b) Address and phone number for your referring physician, gynecologist and primary care physician.

2. Bring all your mammography and ultrasound films from the past five years.

- MAMMOGRAPHY FILMS MUST BE ON PRINTED FILM
- WE WILL ACCEPT DISC FOR ULTRASOUND ONLY
- MRI – TARGETED AREA MUST BE PRINTED

Please check your film jacket before you leave the facility to insure your current and past films are enclosed. This is very important. The doctor needs them for comparison.

3. Please have all insurance information with you. If your plan requires a referral, you are responsible to have it with you at the time of your visit.

4. Co-payment is due at time of visit.

5. If you are using out-of-network benefits, payment in full is due at time of visit.

6. Please arrive 15 minutes prior to your appointment to allow time to check in and review your paperwork.

We accept cash, check, MasterCard, Visa and Discover Card.

It is very important that you follow these instructions to insure you receive the highest quality of care possible. Failure to do so will make it impossible for you to have a complete consultation.

For all returned checks, a $30.00 service fee will be applied.

Thank you in advance for your cooperation.

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Patient Information

Date _____
Co-Payment: $ _____
Referral required? Y N

Please PRINT and complete ALL sections below.

Patient's Personal Information **Marital Status: Single Married Divorced Widowed**

Patient's Name: _____ _____ _____ **Social Security #:** _____
last name first name initial

Street Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____ **Age:** _____

Home Phone: ( ) _____ **Work Phone: ( )** _____ **Cell Phone: ( )** _____

E-mail address: _____ **How would you like to be addressed?** _____

Employer: _____ **Occupation:** _____ **Phone: ( )** _____

Spouse's Name: _____ _____ _____ **Social Security #:** _____
last name first name initial

Date of Birth: _____ **Work Phone: ( )** _____ **Cell Phone: ( )** _____

Employer: _____ **Occupation:** _____ **Phone: ( )** _____

Responsible Party: _____ _____ _____ **Date of Birth:** _____
last name first name initial

Relationship to Patient: Self Spouse Other _____ **Social Security #:** _____

Patient's Insurance Information: **Primary Insurance Company:** _____

Insurance Co. Address: _____ **City:** _____ **State:** _____ **Zip:** _____

ID #: _____ **Group #:** _____ **Phone:** _____
If you are not the insured:
Name of Insured: _____ **Relationship: Spouse Other** _____

Secondary Insurance Company: _____

Insurance Co. Address: _____ **City:** _____ **State:** _____ **Zip:** _____

ID #: _____ **Group #:** _____ **Phone:** _____
If you are not the insured :
Name of Insured: _____ **Relationship: Spouse Other** _____

Referring Physician Name: _____ **Phone #:** _____

OB/GYN: _____ **PRIMARY:** _____

Address: _____ **Address:** _____

Phone: _____ **Fax:** _____ **Phone:** _____ **Fax:** _____

Emergency Contact:
Name: _____ **Relationship:** _____ **Do you have a Living Will? Yes No**
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #: Home: _____ **Work:** _____ **Cell:** _____

Should information be omitted or inaccurately supplied, causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Saint Peter's University Hospital. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient's Signature: _____ **Insured's Signature:** _____

Update:
Patient's Signature: _____ **Insured's Signature:** _____

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Patient's Name: _____ Appointment Date: _____
Date of Birth: _____ Occupation: _____ Ethnic Background: _____

REASON FOR VISIT: (Place 1 before primary reason, then 2, 3, etc. for any other reason for visit)

_____ Lump ❑ Left ❑ Right ❑ Both Date Noticed: _____ Found by: ❑ Doctor ❑ Self

_____ Abnormal Mammogram ❑ Left ❑ Right ❑ Both Comments: _____

_____ Nipple Discharge ❑ Left ❑ Right ❑ Both Date Noticed: _____ Found by: ❑ Doctor ❑ Self

_____ Breast Cancer ❑ Left ❑ Right ❑ Both Comments: _____

_____ Pain ❑ Left ❑ Right ❑ Both Date Noticed: _____ Found by: ❑ Doctor ❑ Self

_____ Other ❑ Left ❑ Right ❑ Both Comments: _____

MAMMOGRAPHY HISTORY

Most recent mammogram date: _____ Where: _____
Prior Mammograms: ❑ Yes ❑ No How Many? _____
Prior Breast Problems: ❑ Yes ❑ No
❑ Lump ❑ Abnormal Mammogram ❑ Nipple Discharge ❑ Breast Cancer ❑ Pain ❑ Other
Prior Breast Biopsy ❑ Yes ❑ No
❑ Stereotactic Biopsy ❑ Ultrasound-guided Core Biopsy ❑ Cyst Aspiration
Prior Breast Surgery ❑ Yes ❑ No
❑ Excision Breast Biopsy
❑ Lumpectomy/Partial Mastectomy with or without Sentinel Lymph Node Biopsy
❑ Lumpectomy/Partial Mastectomy with Axillary Lymph Node Dissection
❑ Mastectomy with or without Reconstruction
❑ Breast Augmentation ❑ Breast Reduction

IF YES TO ANY OF THE ABOVE, PLEASE PROVIDE US WITH ALL PATHOLOGY RESULTS

RISK FACTORS

of pregnancies: _____ # of children: _____ # Male: _____ # Female: _____
Age when first child born: _____ Age of first period: _____ Age of menopause: _____
Last pap smear: _____ ❑ Never ❑ Unknown Findings: ❑ Normal ❑ Abnormal
First day of last menstrual period: _____ Periods: ❑ Regular ❑ Irregular

Have you ever had Hormone Replacement Therapy? If YES, when? _____ How Long? _____

FAMILY HISTORY OF CANCER

Is there a history of BREAST CANCER in your family? ❑ Yes ❑ No

❑ Mother			Age diagnosed _____
❑ Father			Age diagnosed _____
❑ Daughter			Age diagnosed _____
❑ Son			Age diagnosed _____
❑ Sister			Age diagnosed _____
❑ Brother			Age diagnosed _____
❑ Aunt	❑ Maternal	❑ Paternal	Age diagnosed _____
❑ Uncle	❑ Maternal	❑ Paternal	Age diagnosed _____
❑ Grandmother	❑ Maternal	❑ Paternal	Age diagnosed _____
❑ Grandfather	❑ Maternal	❑ Paternal	Age diagnosed _____
❑ Cousin /1st – 2nd	❑ Maternal	❑ Paternal	Age diagnosed _____

Have you had genetic testing done? ❑ No ❑ Yes ❑ Braca 1 + ❑ Braca 2 + ❑ Negative
Have any family members had genetic testing done? ❑ No ❑ Yes ❑ Braca 1 + ❑ Braca 2 + ❑ Negative

Name: _____ **Date of Birth** _____

Is there history of other cancer in your family? ❑ Yes ❑ No

❑ Mother			Age diagnosed _____ Type of Cancer _____
❑ Father			Age diagnosed _____ Type of Cancer _____
❑ Daughter			Age diagnosed _____ Type of Cancer _____
❑ Son			Age diagnosed _____ Type of Cancer _____
❑ Sister			Age diagnosed _____ Type of Cancer _____
❑ Brother			Age diagnosed _____ Type of Cancer _____
❑ Aunt	❑ Maternal	❑ Paternal	Age diagnosed _____ Type of Cancer _____
❑ Uncle	❑ Maternal	❑ Paternal	Age diagnosed _____ Type of Cancer _____
❑ Grandmother	❑ Maternal	❑ Paternal	Age diagnosed _____ Type of Cancer _____
❑ Grandfather	❑ Maternal	❑ Paternal	Age diagnosed _____ Type of Cancer _____
❑ Cousin /1st – 2nd	❑ Maternal	❑ Paternal	Age diagnosed _____ Type of Cancer _____

PAST MEDICAL HISTORY

❑ No significant past medical history
❑ Diabetes type 1 ❑ type 2 ❑ ❑ Heart Disease ❑ Arthritis / Fibromyalgia
❑ Hypertension ❑ Neurological Disorders ❑ Stroke ❑ Bleeding Tendency
OTHER:_____
_____
_____

PAST SURGICAL HISTORY

❑ Complete Hysterectomy ❑ Partial Hysterectomy ❑ Oophorectomy ❑ Cesarean Section
❑ Joint Replacement ❑ Cardiovascular Surgery If yes, explain: _____
OTHER:_____

SOCIAL HISTORY

Tobacco use: ❑ No ❑ Yes Packs per day _____ Years smoking _____
❑ Prior Smoking History: Years smoked_____ Years quit _____
Alcohol use: ❑ Yes ❑ No
Drug use: ❑ Yes ❑ No

ANY PROBLEMS IN THE FOLLOWING AREAS?

❑ Eyes: _____
❑ Ears/Nose/Throat: _____
❑ Heart/Vessels: _____
❑ Lungs: _____
❑ Gastrointestinal: _____
❑ Genito-Urinary: _____
❑ Other: _____
❑ Musculoskeletal: _____
❑ Skin: _____
❑ Neurological: _____
❑ Endocrine: _____
❑ Blood/Lymphatics: _____
❑ Allergy/Immune System: _____
❑ Psychiatric: _____

Reviewed by: MD _____ Nurse: _____ Date: _____

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Description of Medications

Patient Name: _____ Date of Birth: _____

Pharmacy Name: _____ Phone: _____

ALLERGIES: (please list below)	REACTION (please list below)
MEDICATION:	
FOOD:	
TAPE:	
IV CONTRAST DYE:	
LATEX	
OTHER:	

Do you take non-prescription drugs? ❑ NO ❑ YES Please list:
Do you take any vitamins or dietary supplements? ❑ NO ❑ YES Please list:

PRESCRIPTION MEDICATION	DOSAGE (mg , mcg, units, etc.)	BY MOUTH OR INJECTION	TIMES TAKEN PER DAY	WHY DO YOU TAKE THIS MEDICATION?

Medication List Continued: Patient Name: _____
DOB:_____

PRESCRIPTION MEDICATION	DOSAGE (mg , mcg, units, etc.)	BY MOUTH OR INJECTION	TIMES TAKEN PER DAY	WHY DO YOU TAKE THIS MEDICATION?

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PATIENT CONFIDENTIALITY

Patient confidentiality is a prime concern in this office. Therefore, please indicate below with whom our office can or cannot leave a message.

Please check one where appropriate.

	YES	NO	DOESN'T APPLY
Spouse			
Children			
Answering Machine			

Are you able to receive calls at your workplace? _____

May we call you at your workplace and state who is calling? _____

Due to our confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you – the patient.

	YES	NO	DOESN'T APPLY
Spouse			
Children			
Other			

If you have checked YES, please list below.

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Patient Name (please print) _____

Signature: _____ Date: _____

Privacy Policy and Acknowledgement

Practices

Any and all information about you that is collected by The Breast Center at Saint Peter's University Hospital is considered confidential.

You have the right to apply for a copy of information held by us about you, as well as the right to require that it be corrected or updated as appropriate, in accordance with the Data Protection Act 1998.

Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____

Date: _____