SAINT PETER'S Breast Center
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM
Office (732)846-3300/Fax (732)448-9734

IMPORTANT
Patient Instructions

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

   Please print clearly in black or blue ink.

   (a) It is very important we have your complete medical history. Please include all previous surgeries and present medical conditions. Please list all medications and the reason for taking the medication this includes over the counter medications as well.

   (b) The phone and fax number of your referring physician, gynecologist and primary care physician are very important, please make sure you provide them.

2. **Bring all your mammography and ultrasound films and cd's from the past five years.**
3. **If you have had a Tomosynthesis (3-D) Mammogram you must also bring films and cd.**

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

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

4. **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. Photo ID is also required at time of visit.

5. **Co-payment is due at time of visit.**

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

7. Please arrive 25 minutes prior to your appointment to allow time to check in and review your paperwork.

8. **Please fax all paper work prior to appointment. Fax (732)448-9734**

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

For all returned checks, a $25.00 service fee will be applied.

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

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 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: _____ **Can we contact you by email: ☐ YES ☐ NO**

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

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

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

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

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

Secondary Insurance Company: _____

ID #: _____ **Group #:** _____ **Phone #:** _____

If you are not the insured :

Name of insured: _____ _____ _____ **Date of Birth:** _____
last name first name initial

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

If you <u>are not</u> insured: Responsible Party: _____ _____ _____
last name first name initial

Date of Birth: _____ **Social Security #:** _____ **Relationship to Patient: ☐ Self ☐ Spouse ☐ Other** _____

Emergency Contact:

Name: _____ **Relationship:** _____ **Do you have a Living Will? ☐ Yes ☐ No**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: Home: _____ **Work:** _____ **Cell:** _____

Referring Physician Name: **Phone #:** **Fax#:**

OBGYN: _____ **PRIMARY:** _____

Address: _____ **Address:** _____

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

Should inaccurate or omitted information be 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 Breast Center. 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: _____ **Date:** _____

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Height: _____ Blood Pressure: _____
Weight: _____ Bra Size: _____
BMI: _____

Patient's Name: _____ Appointment Date: _____

Date of Birth: _____ Ethnic Background: _____

WHAT IS THE REASON FOR YOUR VISIT_____

_____

_____

Breast History

Date

Have you had any of the following

❑ 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

# of Pregnancies: _____ # of Children: _____Age when first child born: _____ Did you Breastfeed_____

First day of last Menstrual period: _____ Age of first period: _____ Age of Menopause: _____

Have you ever been on Estrogen Replacement Therapy: ❑Yes ❑No How Long: _____

FAMILY HISTORY — HEALTH STATUS

❑ Mother	Age_____	Alive/Deceased	Medical History_____
❑ Father	Age _____	Alive/Deceased	Medical History_____
❑ Sister	Age _____	Alive/Deceased	Medical History_____
❑ Brother	Age _____	Alive/Deceased	Medical History_____
❑ Children	Age _____	Alive/Deceased	Medical History_____

FAMILY HISTORY OF CANCER

❑ 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_____

Have you had Genetic Testing Done? ❑ No ❑ Yes When_____

Have any family members had Genetic Testing Done? ❑ No ❑ Yes Results _____
If yes please bring copy of results

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Name: _____ **Date of Birth** _____

PAST MEDICAL HISTORY

No significant past medical history ❑

❑ Diabetes type 1 ❑ type 2 ❑ ❑ Stents ❑ Hyperlipidemia ❑ Blood clots
❑ Heart Disease ❑ Stroke ❑ Hypertension
❑ Bleeding Tendency ❑ Depression ❑ Anxiety
Other:_____
_____
_____

PAST SURGICAL HISTORY

Have you ever had surgery? Yes❑ No❑

What kind of surgery _____
_____
_____
_____

SOCIAL HISTORY

Tobacco Use: ❑ Never ❑ Current ❑ Prior
Packs per Day _____ Years _____ Smoking History Years smoked_____ Years Quit _____
❑ Patient counseled information given
Alcohol Use: ❑ Yes ❑ No Number of drinks per week _____
Drug Use: ❑ Yes ❑ No

ANY PROBLEMS IN THE FOLLOWING AREAS?

Constitutional: Fever_____ Night sweats_____ Fatigue_____ Significant weight loss/gain_____

Cardiovascular: Chest pain_____ Palpations_____ Shortness of Breath_____ Edema_____ Orthopnea_____

Respiratory: Cough_____ Wheezing_____ Shortness of Breath_____

Gastrointestinal: Vomiting_____ Diarrhea_____ Constipation_____ Abdominal pain_____
Heart burn_____ Difficulty Swallowing_____ Bowel movement changes_____

Genito-Urinary: Blood in urine_____ Flank pain_____Menopause_____Hotflashes_____

Musculoskeletal: Aches_____ Muscle weakness_____ Joint pain_____

Neurological: Loss of consciousness_____ Weakness_____ Numbness_____ Seizures_____
Dizziness_____

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
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 A DAY?	WHY DO YOU TAKE THIS MEDICATION

Medication List Continues:

Patient Name: _____ Date of Birth: _____

PRESCRIPTION MEDICATION	DOSAGE (mg, mcg units, etc)	BY MOUTH OR INJECTION	TIMES A 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	DOES NOT 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	DOES NOT 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 Saint Peter's Breast Center 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: _____