SAINT PETER'S
Breast Center
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

240 Easton, Avenue, 3rd Floor New Brunswick, NJ 08901
Office (732)846-3300/Fax (732)448-9734

Clearbrook Commons Medical & Professional
Office Park
294 Applegarth Road, Ste A
Monroe Township, NJ 08831

# *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/or primary care physician are very important, please make sure you provide them.

2. **Bring ALL your current and past Breast Imaging disks and a hard copy of all reports.**
3. **If you have had a Biopsy, please bring your pathology slides and report.**

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.

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 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.**

*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:

**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: ( )___________

**Preferred # to contact you?** Home❑ Cell❑ Work❑

E-mail address:______________________________ Can we contact you by email: ☐ YES ☐ NO

Employer: ______________________ Occupation: _______________ Phone #: ( ) ______________

Spouse's Name: ________________ ________________ _________ DOB: ______________
last name first name initial

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 are not 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

Phone #: Home:________________ Work: ______________ Cell:________________

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: ______________

Height: __________ Blood Pressure: ____________
Weight: __________ Bra Size: ____________
BMI: __________

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Patient's Name: ____________________________________ Ethnicity:________Appointment Date: ___________

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**WHAT IS THE REASON FOR YOUR VISIT**____________________________________________

____________________________________________________________________________

____________________________________________________________________________

## Breast History

**Have you had Breast Cancer?** Yes❑ No❑
**Treatment?** Yes❑ No❑
**If yes, please provide details:**

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# 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________________________DOB____

**Past Medical History:**

| | | |
|---|---|---|
| No significant past medical history | Yes❑ | No❑ |
| Diabetes | Type 1❑ | Type 2 ❑ |
| Heart Disease | Yes❑ | No❑ |
| Bleeding Tendency | Yes❑ | No❑ |
| GERD | Yes❑ | No❑ |
| Stents | Yes❑ | No❑ |
| Blood Clots | Yes❑ | No❑ |
| Hypertension | Yes❑ | No❑ |
| High Cholesterol | Yes❑ | No❑ |
| Stroke | Yes❑ | No❑ |

**Past Surgical History:**

Have you ever had surgery? Yes❑ No❑

What type/kind of surgery

______________________________________________________________________________

**ANY PROBLEMS IN THE FOLLOWING AREAS?**

**Constitutional:**

| | | |
|---|---|---|
| Fever | Yes❑ | No❑ |
| Night Sweats | Yes❑ | No❑ |
| Fatigue | Yes❑ | No❑ |
| Significant Weight Loss/Gain | Yes❑ | No❑ |

**Cardiovascular:**

| | | |
|---|---|---|
| Chest Pain | Yes❑ | No❑ |
| Palpitations | Yes❑ | No❑ |
| Shortness of Breath while walking | Yes❑ | No❑ |
| Edema | Yes❑ | No❑ |
| Shortness of Breath while lying down | Yes❑ | No❑ |

**Respiratory:**

| | | |
|---|---|---|
| Cough | Yes❑ | No❑ |
| Wheezing | Yes❑ | No❑ |
| Shortness of Breath | Yes❑ | No❑ |

**Mental Health:**

| | | |
|---|---|---|
| Depression | Yes❑ | No❑ |
| Anxiety | Yes❑ | No❑ |
| Trouble with Memory | Yes❑ | No❑ |
| Other Mental Health Ilness | Yes❑ | No❑ |

**Gastrointestinal:**

| | | |
|---|---|---|
| Vomiting | Yes❑ | No❑ |
| Diarrhea | Yes❑ | No❑ |
| Constipation | Yes❑ | No❑ |
| Abdominal Pain | Yes❑ | No❑ |
| Heart Burn | Yes❑ | No❑ |
| Difficulty Swallowing | Yes❑ | No❑ |
| Change in Bowel Movement | Yes❑ | No❑ |

**Genito-Urinary:**

| | | |
|---|---|---|
| Blood in Urine | Yes❑ | No❑ |
| Flank Pain | Yes❑ | No❑ |
| Menopause | Yes❑ | No❑ |
| Hot Flashes | Yes❑ | No❑ |

**Musculoskeletal:**

| | | |
|---|---|---|
| Aches | Yes❑ | No❑ |
| Muscle Weakness | Yes❑ | No❑ |
| Joint Pain | Yes❑ | No❑ |

**Neurological:**

| | | |
|---|---|---|
| Loss of Consciousness | Yes❑ | No❑ |
| Weakness | Yes❑ | No❑ |
| Numbness | Yes❑ | No❑ |
| Seizures | Yes❑ | No❑ |
| Dizziness | Yes❑ | No❑ |

**Breast Related:**

| | | |
|---|---|---|
| Lump | Yes❑ | No❑ |
| Nipple Discharge | Yes❑ | No❑ |
| Cysts | Yes❑ | No❑ |
| Pain | Yes❑ | No❑ |
| Breast Implant/Reduction | Yes❑ | No❑ |

Reviewed By: MD_______________________________Nurse:___________________Date:_________

# Description of Medications

**Patient Name:** ____________________________________________________ **Date of Birth:** ______________________

**Pharmacy Name:** ________________________________________________ **Phone:** __________________________

**Preferred Lab Name:** _______________________________________________ **Phone:** ___________________________

**Imaging Facility 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

______________________________________________________________________________

**Social History**:

Tobacco Use ❑ No ❑ Yes
Alcohol Use ❑ No ❑ Yes
Drug Use ❑ No ❑ Yes

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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: __________________________

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## 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: _____________________________________________

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