

MICHIGAN BREAST SPECIALISTS
PATIENT REGISTRATION INFORMATION FORM

Please Print All information

Referred By: _____

Patient Name: _____ Maiden: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security # _____ Sex: Male Female

Occupation: _____

Employed By: _____

Employer Address: _____

Marital Status: S M D W

Spouse's Name: _____ Birth Date: _____

Social Security # _____

Occupation: _____

Employed By: _____

Employer Address: _____

Work Phone: _____ ext: _____

INSURANCE:

Primary:

Contract #: _____ Group#: _____

Primary Care Physician: _____ Phone #: _____

Cardholder Name: _____ Relation to You: _____

If Insurance Cardholder is different from you or your spouse complete below:

Cardholder Birth Date: _____ Social Security #: _____

Employer Name: _____ Phone #: _____

Employer Address: _____

Primary:

Contract #: _____ Group#: _____

Primary Care Physician: _____ Phone #: _____

Cardholder Name: _____ Relation to You: _____

If Insurance Cardholder is different from you or your spouse complete below:

Cardholder Birth Date: _____ Social Security #: _____

Employer Name: _____ Phone #: _____

Employer Address: _____

Please supply insurance cards so we may copy them for your file.

Patient Signature: _____ Date: _____

Michigan Breast Specialists

PATIENT HIPAA AUTHORIZATION

I hereby authorize you to disclose the specific information only for the purposes of my care and treatment to the parties I authorize below which include; insurance company(s) for treatment and payment; other physicians involved in my care and treatment; and family members that I authorize to receive my medical information.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication be made by alternative means.

Please list the physicians and family members that your protected health information (PHI) may be released to:

This authorization shall remain in effect from the date signed below until December 31, 2010.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office in writing, attn: Paula Labadie, Privacy Officer at 19229 Mack Avenue, Suite 38, Grosse Pointe Woods, MI, 48236.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Patient/guardian signature: _____ Date: _____

You have a right to have a copy of this form after you sign it.
Office Use Only

I wish to be contacted in the following manner regarding test results, scheduling surgical procedures and appointments, etc. (check all that apply):

Home Telephone

- Leave message on answering machine
- Leave message with a family member
- Leave message with call-back number only

- Cellular Phone _____
- Other _____

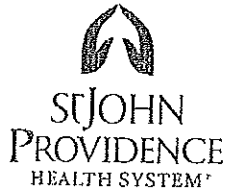
Work Telephone

- Leave message with detailed information
- Leave message with call-back number only

Written Communication

- Mail to home address
- Mail to work address
- Fax to this number _____

Signature: _____ Date: _____



Dear Patient:

As of today, we are required to report statistics on race, ethnicity and preferred language for our patient population. YOUR NAME and ANY OTHER PATIENT IDENTIFIERS OR SPECIFICS WILL NOT BE REPORTED. We appreciate your participation in helping us collect this information.

DATE: _____

PATIENT NAME: _____

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Unreported/Refused to report
-

Race:

- Asian
- Native Hawaiian
- Other Pacific Islander
- Black/African American
- American Indian/Alaska Native
- White
- More than one race
- Unreported/Refused to report

Preferred Language:

- English
- Other
- Indian (including Hindi & Tamil)
- Spanish
- Russian

MICHIGAN BREAST SPECIALISTS: REVIEW OF BREAST SYMPTOMS

Patient Name: _____ DOB: _____ Date: _____

Age at first period: _____ Last Menstrual cycle: _____

Age at menopause: _____ Hysterectomy date: _____ Partial or Complete: _____

Oral birth control, type/duration: _____

Hormone replacement therapy: type, length of use: _____

Pregnancies _____ # Children _____

Age at first full-term pregnancy: _____ Did you breast feed? Yes No Duration _____

Prior breast problems? Yes No explanation: _____

Was surgery required? Yes No Type & date: _____

Breast reduction? Date: _____

Breast augmentation? Date and Type of implant: _____

Nipple discharge? Yes No Left Right Both

Color: _____ Duration: _____ # of episodes: _____

Family history of breast cancer: Yes No (Include maternal and paternal relatives.)

Who? _____ Age at diagnosis: _____

Who? _____ Age at diagnosis: _____

Family history of ovarian cancer: Yes No (Include maternal and paternal relatives.)

Who? _____ Age at diagnosis: _____

Who? _____ Age at diagnosis: _____

Additional comments:

Michigan Breast Specialists: Patient Medical History

What is your reason for today's visit? _____

When did this problem begin? _____

Has there been any change in this problem? Yes No (circle)
 What? _____ How long? _____

Health History

	Yes	No
Are you in good health?	_____	_____
Have there been any changes in your general health in the past year?	_____	_____
Have you had an operation or been hospitalized in the past 5 years?	_____	_____
Do you smoke?	_____	_____ how much/day? _____
Do you drink alcohol?	_____	_____ how much/day? _____

Have You Had or Do You Currently have:

	Yes	No		Yes	No
Heart trouble (mitral valve prolapse)	_____	_____	Constipation	_____	_____
Heart Attack	_____	_____	Liver disease or jaundice	_____	_____
Chest Pain, angina	_____	_____	Hepatitis	_____	_____
Heart Surgery/Bypass/Stents	_____	_____	Stomach ulcers/GERD	_____	_____
Cardiac Pacemaker	_____	_____	Gallbladder disease	_____	_____
Heart murmur/Arrhythmia	_____	_____	Kidney trouble	_____	_____
Rheumatic Fever	_____	_____	Epilepsy/seizures	_____	_____
Vascular Surgery	_____	_____	Delay in healing	_____	_____
Stroke	_____	_____	Chronic fatigue/night sweats	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty breathing	_____	_____	Artificial Joints	_____	_____
Asthma	_____	_____	Placed when? _____	_____	_____
Hay fever/sinus problems	_____	_____	Arthritis/rheumatism	_____	_____
Emphysema/COPD	_____	_____	Glaucoma/eye disease	_____	_____
Bronchitis/chronic cough	_____	_____	Thyroid trouble	_____	_____
Tuberculosis	_____	_____	Mental Health issues	_____	_____
Anemia	_____	_____	History of alcohol abuse	_____	_____
Leukemia	_____	_____	History of drug abuse	_____	_____
Cancer	_____	_____	Surgery	_____	_____
Type: _____	_____	_____	Type and date: _____	_____	_____
Radiation/chemotherapy	_____	_____		_____	_____

Family History-Is there a family history of:

	Yes	No	Relation to you:
Anesthetic problem	_____	_____	_____
Bleeding disorders	_____	_____	_____
Diabetes	_____	_____	_____
Heart disease	_____	_____	_____
Kidney disease	_____	_____	_____
Systemic Lupus	_____	_____	_____
Cancer of:	_____	_____	_____
breast,	_____	_____	_____
colon,	_____	_____	_____
ovaries or prostate	_____	_____	_____
thyroid	_____	_____	_____
other	_____	_____	_____

Medications:

Please list all medications and herbal/vitamin supplements with dosage that you take daily :

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Allergies: Are you allergic to, or have you ever had a reaction to the following?

	Yes	No	Reaction		Yes	No	Reaction
Penicillin	___	___	_____	Aspirin	___	___	_____
Antibiotics	___	___	_____	Sulfa Drugs	___	___	_____
Acetaminophen (Tylenol)	___	___	_____	Codeine	___	___	_____
Sedatives	___	___	_____	Other medicine	___	___	_____
Food Allergies	___	___	_____	Latex	___	___	_____
Other food or drug : _____				Iodine	___	___	_____
				CT Scan contrast	___	___	_____

Anesthesia

	Yes	No	Notes
Have you ever had general anesthesia?	___	___	_____
Have you ever had a reaction to general or local anesthesia?	___	___	_____

Patient Signature : _____ Date: _____

(Parent or guardian, if patient is a minor)

Reviewed with patient: _____ Date: _____