THE BREAST CARE CENTER, PC
PATIENT REGISTRATION FORM

ACCT# ________

BILLING/GUARANTOR INFORMATION **DATE: ________**

First Name: ________ MI: ____ Last Name: ________

Address: ________

City: ________ State: ________ Zip: ________

TELEPHONE: ( ) ________ CELL #: ________

ALTERNATE #: ________

PATIENT INFORMATION

First Name: ________ MI: ____ Last Name: ________

Address: ________

City: ________ State: ________ Zip: ________

Telephone: (____) ________ Emergency Phone: (______) ________

Birth Date: ________ Sex: ________ Martial Status: ________

Social Security No. ________ Referring Physician: ________

Maiden/Previous Name: ________ Spouse's Name: ________

Patient's Employer: ________

Employer's Address: ________ Suite #: ______

City: ________ State: ________ Zip: ________

Employer Phone: (______) ________ Email: ________

INSURANCE INFORMATION

PRIMARY INSURANCE: ________

Group No: ________ Policy No: ________ Copay Amt: ______

Subscriber Name: ________ Relationship to Patient: ______

Subscriber Sex: ________ DOB: ________ SSN: ________

Subscriber Employer: ________ Work Phone: ________

Employer Address: ________

SECONDARY INSURANCE: ________

Group No: ________ Policy No: ________ Copay Amt: ______

Subscriber Name: ________ Relationship to Patient: ______

Subscriber Sex: ________ DOB: ________ SSN: ________

Subscriber Employer: ________ Work Phone: ________

Employer Address: ________

PATIENT INFORMATION

Today's Date ______________________

Last Name: ________________________ First Name: ________________________

Date of Birth: ___________________________________

RACE:

____ African American

____ Alaska Native

____ American Indian

____ Asian

____ Hispanic

____ Native Hawaiian

____ White

____ Other

ETHNICITY:

____ Hispanic or Latino

____ Not Hispanic or Latino

PRIMARY LANGUAGE: ____

____ I elect to OPT OUT and not complete questionnaire ______________________
SIGNATURE

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with insurer).
I directly assign all medical/surgical benefits to The Breast Care Center, P.C. and understand that I am financially responsible for all charges not covered by insurances. I hereby authorize The Breast Care Center, P.C. to release all information necessary to secure the payment of benefits. In the event of non-payment, either by insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

In order to help control the cost of billing, we request payment be made for all office services at the conclusion of your visit unless other arrangements have been made prior to services being rendered.

________________________________ ________________________________

Signature of Patient or Legal Representative Date

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, and information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

________________________________ ________________________________

Signature of Patient or Legal Representative Date

_______ **I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information. I authorize the Breast Care Center, P.C. to fax my information to any party involved in my health care.**

The Breast Care Center

CANCELLATION POLICY

Effective December 1, 2014, a $35.00 fee will be assessed for cancellations occurring within one business day of scheduled appointment.

____
Printed Name

________________________________ Date: ______________
Signature

THE BREAST CARE CENTER, P.C.
910 Adams Street, Suite 130
Huntsville, Alabama 35801
(256) 265-7966 Fax (256) 265-7965

RICHARD P. RICHARDSON, M.D.

Due to recent federal privacy guidelines (HIPPA), The Breast Care Center, P.C is not allowed to divulge medica or financial information to anyone other than the patient (of guardian in the case of a minor) unless explici authorization is given

To authorize the breast care center to discuss your medical information with someone other than yourself, pleas fill in below.

I, ______________________ give The Breast Care Center, P. C, permission to release/discuss personal medical and/or financial information to/with:

Name of Person	Relationship to Patient	Phone #
Name of Person	Relationship to Patient	Phone #
Name of Person	Relationship to Patient	Phone #

______________________ ______________
Signature of Patient Date

PHARMACY INFORMATION

Pharmacy Name:______________________

Pharmacy Address:______________________

Pharmacy Telephone Number:______________________

PATIENTS NAME ____________ DATE OF BIRTH ____________ DATE ____________ ACCT # ____________

DO YOU HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING:

I. Gastro-Intestinal

Internist you have seen: ____________

	Yes	No	When
Ulcers	___	___	___
Jaundice	___	___	___
Hepatitis	___	___	___
Vomiting Blood	___	___	___
Blood In Stool	___	___	___
Hemorrhoids	___	___	___
Rectal Bleeding	___	___	___
Unexplained Diarrhea	___	___	___
Constipation	___	___	___
Unexplained Weight Loss	___	___	___
Gallbladder Trouble	___	___	___
Difficulty In Swallowing	___	___	___
Indigestion And/Or Heartburn	___	___	___
Regurgitation Of Food Or Liquid	___	___	___

II. Urologic

Urologist you have seen: ____________

	Yes	No	When
Kidney Infections	___	___	___
Blood In Urine	___	___	___
Prostate Trouble	___	___	___
Kidney Stones*	___	___	___

III. Female

Gynecologist you have seen: ____________

	Yes	No	When
Irregular Menstrual Periods	___	___	___
Bleeding After Intercourse	___	___	___
Painful Intercourse	___	___	___
Loss Of Urine With Straining	___	___	___
Vaginal Bleeding After Menopause	___	___	___
Lumps In Breast L R	___	___	___
Mastitis L R	___	___	___
Nipple Discharge L R	___	___	___
Taking Birth Control Pills	___	___	___
Taking Hormone Pills	___	___	___

Number of Pregnancies ______ Miscarriages ______

Date of last menstrual period ____________

Ages of Children ____________

IV. Heart And Lungs

Cardiologist you have seen: ____________

	Yes	No	When
Heart Attacks	___	___	___
Coughing Blood	___	___	___
Pneumonia	___	___	___
Chest Pain with Exertion	___	___	___
Irregular Heart Breath	___	___	___
Shortness of Breath with Exertion	___	___	___
High Blood Pressure	___	___	___
Low Blood Pressure	___	___	___

V. Vascular

	Yes	No	When
Phlebitis	___	___	___
Leg Pain with Walking	___	___	___
Impotency	___	___	___
Night Leg Cramps	___	___	___
Swollen Legs & Ankles	___	___	___
Paralysis	___	___	___
Strokes	___	___	___
Convulsions	___	___	___
Unconsciousness	___	___	___

VI. Miscellaneous

	Yes	No	When
Arthritis	___	___	___
Cancer	___	___	___
Thyroid Disease	___	___	___
Diabetes	___	___	___
Enlarged Lymph Glands	___	___	___
Anemia	___	___	___
Hernia	___	___	___

Other Diseases: ____________

1. Age ______
2. Age of your first period ______
3. Your age at your first live birth ______
4. Number of mother/sister(s)/ daughters(s) with breast cancer ______
5. Number previous breast biopsies ______
6. ____________

VII. **Family History**

Diabetes: ______________________ **Relationship:** ______________________

Heart Disease: ______________________ **Relationship:** ______________________

Cancer: ______________________ **Relationship:** ______________________

Stroke: ______________________ **Relationship:** ______________________

PREVIOUS SURGERIES	DATE	DR. WHO PERFORMED SURGERY OR HOSPITAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ALLERGIES: ____

MEDICATIONS: ____

____

Use of Alcohol: None ______________ Occasional: ______________ Frequent: ______________

Use of Tobacco: None: ______________ Number of Packs Per Day: ______________ Number Of Years: ______________

Physician Notes:

The Breast Care Center
Richard P. Richardson, M.D., F.A.C.S.
910 Adams Street
Suite 130
Huntsville, AL 35801
256.265.7966 Fax 256.265.7965

Authorization for Release / Request of protected Health Information

Patient Name: ______________________ Date of Birth: __________
Address: ____
City/State/Zip: ____
SS #: ____________________ Patient's phone #: _______________

Date of Request: _____________ Date Needed: __________________

For Office Staff use only:

o I authorize The Breast Care Center to <u>release</u> information to:	OR	I authorize The Breast Care Center to <u>obtain</u> information from:
______________________ Name of Provider or Facility		______________________ Name of Provider or Facility
______________________ Address		______________________ Address
______________________ City, State, Zip		______________________ City, State, Zip
______________________ Phone # / Fax #		______________________ Phone #/ Fax #

Purpose for this request / Types of records requested:

- o Copy of medical records
- o X-rays or results
- o Lab results
- o Operative Report
- o Office Notes
- o Other __________

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a <u>written</u> request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Medical records are faxed in cases of medical necessity.

Signature of Patient ____________________________ Date ___________

Witness ____________________________