South Florida Breast Specialists

Denise Sanderson, M.D.
Karissa Richards, A.P.R.N.
2220 SE Ocean Blvd, Suite 203
Stuart, FL 34996
Phone (772) 872-6913 Fax (772) 872-6924

First Name:_____ Middle Initial:_____ Last: Name_____

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

Email:_____ Date of Birth:_____

Social Security Number: _____ Sex: ( ) Male ( ) Female

Home Phone: _____ Work:_____ Cell:_____

Preferred Phone Number: ( ) Home ( ) Work ( ) Cell Preferred Language:_____

Race/Ethnicity/Ancestry: ( ) Black ( ) White ( ) Hispanic ( ) Pacific Islander ( ) Asian

( ) American Indian/Native Indian ( ) Ashkenazi Jewish Descent ( ) Other _____

Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

Work Status: ( ) Not Employed ( ) Full Time ( ) Part Time ( ) Disabled ( ) Retired

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

Referring Provider:_____ Primary Care Provider:_____

Pharmacy Name:_____ Address:_____

Phone Number:_____ Fax:_____

Advanced Directives? ( ) Living Will ( ) DNR Power of Attorney:_____

CONSENT FOR MEDICATION HISTORY

Do you consent for South Florida Breast Specialists to obtain your medication history from your pharmacy electronically if they are available? ( ) YES ( ) NO

INSURANCE INFORMATION

PRIMARY Insurance:_____ SECONDARY Insurance:_____

Policy Holder (If other than self):_____ SS#:_____

Relationship to patient:_____Date of Birth:_____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. DENISE SANDERSON. I REALIZE THAT I AM RESPONSIBLE TO PAY NON-COVERED SERVICES (INCLUDING COLLECTION COSTS IN THE EVENT OF DEFAULT). A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS ORIGINAL. I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO SECURE PAYMENT.

PATIENT SIGNATURE:_____ DATE:_____

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FINANCIAL POLICIES & OFFICE PROCEDURES

Thank you for choosing South Florida Breast Specialists and welcome to our practice. We want you to understand our patient payment and office policies in advance so any misunderstanding may be avoided. Our office makes a great effort to get insurance companies to pay their share of cost in a timely manner.

By signing below, you accept financial responsibility for all services rendered.

(Initial)_____ We will file claims to the participating insurance companies as a courtesy to you- you are responsible for all the remaining balances. We will bill your insurance company only if we are in network, you are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. I understand that I am responsible to provide my current insurance coverage at every visit. I will be responsible for paying any balance as a result of not providing current information. I understand that South Florida Breast Specialists will not retroactively file claims beyond 90 days due to my failure to provide current insurance information.

(Initial)_____ I understand that many health insurance plans will not pay for specialists doctor visits without an authorization being approved by your PCP in advance (HMO plans). It is your responsibility to contact your primary care office to request the appropriate insurance referral prior to your appointment with us.

(Initial)_____ If we do not receive payment from your insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days from the date of service and you must pay the outstanding balance in full. You are responsible for calling your insurance carrier, at our request, to expedite payment for delayed claims.

(Initial)_____Payment (co-payment, co-insurance, or deductible) is due at the time of service. If you have an outstanding balance, it will be collected at the same time.

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(Initial)_____South Florida Breast Specialists will mail statements to the address provided to us by you. If your address changes, you are responsible for notifying us. Payment is due upon receipt of the first statement. Payment plans are available to patients with financial difficulty, however, it is your responsibility to contact our billing specialists to request assistance before the account becomes delinquent. If your account remains unpaid beyond 90 days your account may be turned over to a collections agency. We will no longer be able to provide health care services to accounts in collections.

(Initial)_____We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide. It is your responsibility to know your benefits before the service is rendered and decline any service you do not wish us to perform. In the event your insurance carrier determines that a service is "not covered" under your policy, you will be responsible for payment. We will not change a procedure or diagnosis code in order for it to be paid.

(Initial)_____ When making your appointment, we are reserving a specific amount of time for your particular needs. If you need to reschedule or cancel your appointment please kindly notify us at least 24 hours prior to the appointment. A "NO SHOW" RESULTS IN A $25 FEE. After 3 no show appointments, our office reserves the right to discharge you from our practice due to non-compliance with our policies. If you are more the 15 minutes late we reserve the right to reschedule your appointment.

(Initial)_____South Florida Breast Specialists charges a $25 fee for all forms that have to be completed by the providers and medical record requests. There is a $3 fee for ANY credit card transaction that is $30+ All checks that are returned to us will incur a fee of $25.00. Once a check is returned that you have given us, we will no longer accept a check from you.

Signature:_____

Date:_____

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By signing this form, you are granting consent to Dr. Denise Sanderson, M.D. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to amend your protected health information for the purposes of treatment, payment or health care operations, in writing, explaining your reasoning for the amendment. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

I understand and authorize, that at times it will be necessary for Dr. Sanderson and/or Staff to call my home or place of business and leave messages on an answering machine, voice mail or e-mail.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request.

Signature:_____

Date:_____

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FAMILY AND FRIEND RELEASE OF INFORMATION

I give permission to allow into the exam room, discuss my care with, and release information to the following listed individuals:

NAME	RELATIONSHIP	PHONE NUMBER

Patients Printed Name

Patients Signature Date

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REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of your appointment here today. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less than optimal function.

CONSTITUTIONAL

- ☐ Chills
- ☐ Daytime drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight gain
- ☐ Weight loss

EYES

- ☐ Use of corrective lenses
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration

EAR/NOSE/THROAT

- ☐ Difficulty/loss of hearing
- ☐ Ringing in the ears
- ☐ Frequent ear aches
- ☐ Discharge from the ear
- ☐ Attacks of vertigo
- ☐ Sinus trouble
- ☐ Nasal blockage
- ☐ Frequent sneezing
- ☐ Frequent sore throat
- ☐ Snoring
- ☐ Recent change in voice quality
- ☐ Sleep apnea
- ☐ Difficulty in swallowing
- ☐ Nose bleeds

Respiratory

- ☐ Asthma
- ☐ Recent bronchitis or chest cold
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ COPD
- ☐ Wheezing

CARDIOVASCULAR

- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Chest discomfort
- ☐ Fluid on the lungs
- ☐ Stroke
- ☐ Blood clot in artery or vein
- ☐ "Black out spells"
- ☐ Aneurysm of any blood vessel
- ☐ Swelling of the legs
- ☐ Heart surgery

GASTROINTESTINAL

- ☐ Ulcer
- ☐ Frequent heartburn or indigestion
- ☐ Hiatal hernia
- ☐ Acid Reflux
- ☐ Poor appetite
- ☐ Gall bladder attacks
- ☐ Chronic constipation
- ☐ Bright blood bowels or rectum
- ☐ Abnormal stool
- ☐ Liver disease or jaundice

Kidneys/Urinary Tract

- ☐ Kidney disease or failure
- ☐ History of kidney dialysis
- ☐ Kidney stones or infection
- ☐ Pain/burning with urination
- ☐ Trouble starting urinary stream
- ☐ Dribbling or incontinence
- ☐ Frequent night urination
- ☐ Bladder infections during the past year
- ☐ Blood in urine during past year

MUSCLES/BONES JOINTS

- ☐ Arthritis
- ☐ Chronic back trouble
- ☐ Bone or joint surgery in the past year

NERUOLOGICAL

- ☐ Migraines
- ☐ Epilepsy or seizures
- ☐ Date of last seizure

_____

ENDOCRINE/METABOLISM

- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Unusual hair loss or growth
- ☐ Goiter
- ☐ Diabetes

BLOOD

- ☐ Bleeding or bruising tendency
- ☐ Previous blood transfusion
- ☐ History of hepatitis

PSYCHOLOGIC

- ☐ Anxiety
- ☐ Loss or change in appetite
- ☐ Behavioral change
- ☐ Bi-polar disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory loss
- ☐ Mood change

_____
INITIAL

_____
DATE

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Breast History:

Why are you here today:

( ) My doctor feels something in my breast

( ) I feel something in my breast

( ) Abnormal breast imaging (Mammogram, ultrasound, MRI)

( ) Breast Pain

( ) Other_____

( ) Skin Changes on the breast

Have you ever had a breast biopsy? ( ) YES ( ) NO Which Breast? ( ) LEFT ( ) RIGHT

If you marked yes, what were the results? ( ) Malignant (cancer) ( ) Benign (it was NOT cancer)

If Malignant, describe the treatment you had below: (Surgery, Chemotherapy, Radiation, Etc.)

_____

_____

_____

Have you ever had genetic testing? ( ) YES ( ) NO If yes, what were the results?_____

MEDICAL HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

Please list all allergies

_____

_____

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PERSONAL HABITS

TOBACCO

- ☐ Yes- Packs per day: _____
- ☐ No
- ☐ Quit- Date:_____

ALCOHOL

- ☐ Yes- Drinks per day: _____
- ☐ No
- ☐ Quit- Date:_____

CAFFEINE

- ☐ Yes- How Much:_____
- ☐ No
- ☐ Quit

RECREATIONAL DRUGS

- ☐ Yes
- ☐ No
- ☐ Quit- Date:_____

MEDICATIONS

Please list all medications INCLUDING over the counter vitamins/supplements that you are currently taking

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please list any SIGNIFICANT family medical conditions. Examples: Cancers, Heart disease, diabetes

Mother:_____

Father:_____

Sisters:_____

Brothers:_____

Other:_____

GYNECOLOGICAL HISTORY

Age at first period:_____ Are you still having periods? ( ) YES ( ) NO Date of last period:_____

If yes, are they regular? ( ) YES ( ) NO If no, how old were you when they stopped?_____

Why did they stop? ( ) Menopause ( ) Hysterectomy ( ) Ablation # of Pregnancies:_____

# of Live births:_____ Did you breast feed? ( ) YES ( ) NO Age at first pregnancy:_____

Contraceptives (Yes/No, What type? How Long?)_____

Hormone Replacement Therapy (Yes/No, What type? How long?)_____