2223 Hemby Lane
Greenville, NC 27834
Phone: (252) 413-0036
Fax: (252) 413-0038

CAROLINA BREAST & ONCOLOGIC SURGERY
Your Partner in Breast Health & Breast Cancer Care

MRN:_____

DEMOGRAPHIC INFORMATION

*All information is strictly confidential. (****REQUIRED****)*

Date:_____ Reason for visit:_____

First Name: _____ ***MI:** ____ **Last name:** _____ **Birthdate:** _____

Street: _____ City: _____ State: _____ Zip:_____

***Email:** _____ ***SS#:**_____

***Gender:** □ M □ F ***Marital Status:** □ Married □ Single □ Divorced □ Widowed □ Other: _____

***Race:** □ Am Ind/Alaska □ Asian □ Black/Afr Am □ Pac Isl/Hawaiian □ White □ Other: _____

***Ethnicity:** □ Latino □ Non-Latino * **Language:** □ English □ Spanish □ Other: _____

***Best Number** to be reached: (_____)_____ Secondary Phone Number: (_____)_____

Employer Name: _____ Work Phone Number: (_____)_____

Emergency Contact: _____ Relationship: _____

Primary Phone Number: (_____)_____ Secondary Phone Number: (_____)_____

***Referring Provider:** _____

***Preferred Pharmacy:** _____

***Primary Care Provider:** _____

(We will send notes from today's visit to your referring physician for continuity of care purpose.)

Authorization for Use/Release of Health Information

From time to time, patient's family, friends or relatives call our office asking for appointment times, medication refills, medical information regarding the patient's diagnosis, or to receive and discuss a patient's results. Without your permission, we CAN NOT talk to anyone about your treatment, other than you, our patient. If you would like our staff to be able to speak to anyone other than yourself, regarding your healthcare, please list the names of those people below: I understand that Carolina Breast & Oncologic Surgery assumes no responsibility for the use or misuse of my health information disclosed under this authorization. I release Carolina Breast from all legal responsibility that may arise from this authorization.

_____ _____

_____ _____

_____ _____

Notice of Privacy Practices Consent

My signature below indicates that I have been given an opportunity to review a current copy of Carolina Breast & Oncologic Surgery "Notice of Privacy Practices". My signature below means that I agree to allow Carolina Breast & Oncologic Surgery to use and disclose the patient's personal health information to carry out treatment, payment and healthcare operations. If I revoke this consent, CBOS does not have to provide further health care services to the patient.

Insurance Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to the healthcare providers at Carolina Breast & Oncologic Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Carolina Breast & Oncologic Surgery may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services provided and determining insurance benefits or the benefits payable for related services.

My signature below verifies that I understand and further agree to the Authorization for Use/Release of Health Information Policy, Notice of Privacy Practices Consent and Insurance Assignment and Release as directed above.

_____ _____

Signature of Patient, Beneficiary, Guardian or Representative Date

_____ _____

Printed Name of Patient, Beneficiary, Guardian or Representative Relationship to Patient

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MRN:_____

Date: _____

HEALTH HISTORY

All information is strictly confidential

Name:	Date of Birth:

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONNAIRE

Current Complaints *(Please check symptoms you currently have)*

General:	**Lung:**	**Gastrointestinal:**	**Muscle Joints:**	**Psychological:**
□ Recent Illness □ Weight Loss □ Weight Gain	□ Chronic Cough □ Waking Up with Shortness of Breath □ Difficulty Breathing	□ Blood in Stool □ Persistent Diarrhea □ Difficulty Swallowing	□ Muscle/Joint Pain □ Back Trouble □ Trouble Walking	□ Anxiety □ Depression □ Mood Swings
Skin:	**Cardiovascular:**	**Genitourinary:**	**Neurologic:**	**Endocrine:**
□ Easy Bruising □ Rash / Hives □ Changing Moles	□ Chest Discomfort □ Ankle/Foot Swelling □ Shortness of Breath while laying flat	□ Unexplained Vaginal Bleeding □ Blood in Urine □ Frequent Urination □ Painful Urination	□ Blindness □ Fainting □ Seizures	□ Heat Intolerance □ Cold Intolerance □ Excess Thirst

Medical History *(Please check medical conditions you HAVE currently or HAD in the past)*

□ Heart Disease □ Heart Attack □ Stroke □ High Cholesterol □ Diabetes	□ COPD/Emphysema □ Asthma □ Sleep Apnea □ Goiter □ High Blood Pressure	□ Anemia □ Bleeding Disorder □ Hepatitis A, B or C □ HIV/AIDS □ Arthritis	□ Migraines □ Stomach Ulcers □ Glaucoma □ Psychiatric Problem □ Anxiety Disorder	□ Depression □ Kidney Disease □ Cancer (what kind and when): _____ _____ _____

Surgical History (*Please list any surgery you have had in the past as well as the date below*)

Surgery:	**Date:**

OVER

Current Medications: ***(Please list ALL medications and/or supplements and doses you are currently taking)***

Medication:	**Dosage:**

Allergies to medications ***(please list below)*****:** **Reaction:**

Family History: (*Please check any conditions that run in your family*)

□ Heart Disease	Cancer:
□ High Blood Pressure	□ Breast: Relation:_____ Age:_____
□ Stroke	□ Colon: Relation:_____ Age:_____
□ Diabetes	□ Ovarian: Relation:_____ Age:_____
□ Arthritis	□ Uterine: Relation:_____ Age:_____
□ Kidney Stones	□ Other:_____
	□ Other:_____

WOMEN only: Date of Last Menstrual Period: _____ Number of children: _____ Contraceptives/HRT: _____
Age at first menstrual cycle: _____ Age at first live birth: _____

Social History:

Do you smoke tobacco? YES NO Packs per day?_____ # years:_____
Do you drink alcohol? YES NO Drinks per day?_____ Per week:_____
Occupation:_____

Advance Care Plan:

Do you have an Advance Care Directive (DNR, Do Not Resuscitate or Living Will)? YES NO
Do you have a Durable Power of Attorney for Health Care or a Health Care Proxy appointed? YES NO
If YES, Who is your Power of Attorney or Health Care Proxy? _____

To the best of my knowledge, the above information is correct and complete. I understand that it is my responsibility to inform my doctor if I have a change in health.

_____ _____
Signature of Patient, Beneficiary, Guardian or Representative Date

_____ _____
Printed Name of Patient, Beneficiary, Guardian or Representative Relationship to Patient