REGISTRATION FORM **Date_____**

Section I: Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security Number: _____

Address: _____City:_____ State: _____ Zip: _____

Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Employer Name: _____ Occupation: _____

Email: _____

Marital Status: _____Spouse_____ DOB_____

Referring Physician: _____Telephone/Location: _____

Reason for visit_____ How did you hear about us? _____

Primary Physician/Location/Telephone:_____

OB/GYN/Location/Telephone:_____ Preferred Pharmacy & Telephone _____

Section II Emergency Contact

Contact Name_____Relationship_____Phone_____

Contact Name_____Relationship_____Phone_____

Section III Insurance Information

Primary Insurance: _____ Policy Number: _____

Policy Holder _____ DOB_____ SSN: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance: _____ Policy Number: _____

Policy Holder _____ DOB_____ SSN: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

PATIENT NAME: _____ DOB: _____
Reason for visit_____

Past Medical History

Blood	Yes	No	Breast	Yes	No	Muscular/skeletal	Yes	No
Transfusion			Cancer			Osteoporosis		
Leukemia			Fibrocystic Disease			Arthritis		
Clotting disorder			Breast Pain			Fibromyalgia		
Other:			Abnormal Mammo			Fractures		
			Nipple Discharge			Other"		
Endocrine			Implants					
Diabetes			Other:			**Neuro**		
Thyroid						Seizure		
Other:			**Gastro**			Brain Tumor		
			Ulcers			Migraines		
Heart/Vascular			Reflux			Tremor		
Heart Attack			Gallstones			Restless legs		
Aneurysm			Irritable Bowel			Other:		
Valve disorder			Liver Disease					
High blood pressure			Hiatal Hernia			**Skin**		
Pacemaker			Colon Cancer			Cancers		
Carotid Artery Disease			Other:			Melanomas		
Heart Failure						Lipomas		
Stroke			**Urinary**			Eczema		
High cholesterol			Frequent infections			Other		
Other:			Blood in urine					
			Other:			**Psych**		
Lungs						Depression		
Asthma			**Other**			Bipolar		
COPD/Emphysema			Alcoholism			Panic		
Other:			Drug Use			Schizophrenia		
			Attention Disorder			Other:		
			HIV					
			Hepatitis					
			TB					
			Other:					

Surgical History

Date	Surgery	Complications	Physician	Hospital

THE BREAST PLACE
•EMPOWERING WOMEN•

PATIENT NAME: _____ **DOB:** _____

Social History

Caffeine:

Coffee, tea, or soda **How many per day?** _____

Smoking:

Packs per day_____ **Number of years**_____ **Year Stopped** _____

◯ **Pipe** ◯**Cigars** ◯**Chew**

Alcohol:

Drinks per day _____**Drinks per week** _____ **Year Stopped** _____

Family History

Relationship	Age if living	Age at death	Present Condition/Diseases

Review of Body Systems: (Circle all that are applicable and explain if needed)

General/Constitutional	Chills Fever Fatigue Other:
Head	Headaches Other:
Heart/Cardiovascular	Chest pain/pressure Irregular beats Swollen ankles Shortness of breath Other:
Lungs	Wheezing Cough Hx of TB Other:
GI	Nausea/vomiting Diarrhea Abdominal pain Other:
Urinary	Frequent infections Other:
Breasts	Pain Rash Nipple discharge Lump Other:
Skin	Rash New skin lesion Skin cancer Melanoma Other:
Neuro	Seizure disorder Fainting spells Dizziness Other:
Musculoskeletal	Muscle pain Joint pain Back pain Other:
Endocrine	Heat/Cold intolerance Unexplained weight loss/gain Hot flashes Other:
Psych	Anxiety Depression Panic disorder Other:
Heme/Lymph	Easy bleeding/bruising Anemia Enlarged lymph nodes Other:

Medication

Please include prescribed, herbal, and over-the-counter medications

Name	Dosage	Directions

Any drug reactions or allergies? _____

PATIENT NAME: _____ DOB: _____

Breast Cancer Risk Factors

Height:_____ Weight?_____
Last Mammogram: _____ Where? _____

Age at onset of periods _____
Last menstrual period _____
Age at menopause _____
Number of pregnancies _____
Number of live births _____
History of breast biopsy _____

Age at first birth _____
Years on birth control _____
Years on hormone replacement _____
Months breastfeeding _____
History of radiation to chest_____

Race/Ethnicity (Please circle)

Caucasian Asian African American Hispanic Ashkenazi Jewish Other _____

Family History of Breast and Ovarian Cancer
Any family diagnosed with Breast Cancer before age 50? Yes/No Who? _____

Any family diagnosed with Breast Cancer at or after age 50? Yes/No Who? _____

Any family diagnosed with Ovarian Cancer at any age? Yes/No Who? _____

Additional person(s) to release medical information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

1. **TREATMENT AUTHORIZATION:** I, the below named patient, do herby give The Breast Place and any other associated provider consent for medical treatment.

   _____ Initial

2. **RELEASE OF INFORMATION:** I, the below named patient, do herby authorize The Breast Place and any associated provider examining and/or treating me to release to any third-party payer (such as an insurance company or governmental agency such as Blue Cross or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third-party for its use in connection with determining a claim for payment for such treatment and diagnosis.

   _____ Initial

3. **PHYSICIAN INSURANCE ASSIGNMENT:** I, the below named subscriber, hereby authorize payment directly to any physician of The Breast Place and any other associated provider examining or treating the patient for any surgical and/or medical benefits herein specified and otherwise payable to me for their services as described, but not to exceed the reasonable and customary charge for such services.

   _____Initial

4. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

   _____ Initial

5. **HIPAA** (Health Insurance Portability and Accountability Act) Notification: I acknowledge my receipt of a copy of The Breast Place Notice of Privacy Practices.

   _____ Initial

PATIENT NAME: _____

PATIENT SIGNATURE: _____

SUBSCRIBER SIGNATURE (if different from patient): _____

DATE: _____

FINANCIAL POLICY FOR PATIENT CARE SERVICES

Patients are responsible for all copays, co-insurance, and deductibles at the time of service. If further services are needed after your initial visit, our billing department will contact your insurance company and verify coverage and benefits for your procedure. Copays, co-insurance, and deductibles **may be due prior to your procedure.**

_____Initial

A statement will be mailed out for any unpaid balances. Statements that go unpaid will begin a collections process after three months. If any account is assigned to an attorney for collections and/or suit, you will be entitled to reasonable attorney fees and cost of collection.

_____Initial

Uninsured patients may speak directly with the billing department. **Self-pay patients are required to pay at time of service and prior to any surgery.** The billing department will be available to discuss ways to help you meet your financial obligations.

_____Initial

There will be a $15.00 charge for filling out any outside paperwork. Outside paperwork will be ready within 3-7 working days. Examples include disability claims, cancer policy claims, FMLA paperwork (per family member), and any other outside paperwork. There will be a $25 for any paperwork needed to be returned same day or within 24 hours.

_____Initial

There will be a $25.00 charge for missed appointments without a 24 hour notice. A $150.00 charge will be applied for surgery no show and cancellations without 48 hour notice.

_____Initial

We strive to discuss financial expectations openly and prior to services. Always ask if you have any questions about your statement or charges. Our billing department will be happy to answer any questions you may have. However, our providers cannot discuss payment with you. Please do not ask them to discuss financial matters.

I understand the above financial policy and my responsibility.

The Breast Place billing phone number: (843) 797-1941.

Patient Signature: _____

Print Name: _____

Date: _____

THE BREAST PLACE

JENNIFER BEATTY, DO, FACS * JENNIFER FIORINI, MD, FACS

2910 TRICOM STEET SUITE 201

CHARLESTON, SC 29406

843-797-1941

843-574-1698 FAX

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Patient Address: _____

_____

DOB:_____ SSN:_____

Phone Number: _____

I, _____, do hereby authorize_____

to release records.

INFORMATION RELEASE TO: The Breast Place

Dr. Jennifer Beatty
Dr. Jennifer Fiorini
2910 Tricom Street, Suite 201
Charleston, SC 29406

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. Understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving the information.

_____ _____

Signature of patient or legal representative Date