CAPITAL HEALTH CENTER FOR COMPREHENSIVE BREAST CARE

Medical History Form

Name:_____ DOB:_____

Reason for appointment:_____

Referring Physician:_____

Primary Care Physician:_____

Other MD:_____

Do you take any prescription or non - prescription medication, vitamins or herbals?	Yes No	Please list with reason why you take med:
Are you allergic to any medication or food?	Yes No	List:
Do you or have you smoked tobacco?	Yes No	How much: How many years: Quit:
Do you drink alcohol?	Yes No	How much/often:
Have you ever used illicit drugs?	Yes No	When and what kind:
Do you bleed or bruise easily?	Yes No	
Have you ever been hospitalized?	Yes No	When and why?
Have you ever had surgery?	Yes No	When and why?
Have you ever had a problem after anesthesia?	Yes No	What:
Are there any non-cancer illnesses that run in the family?	Yes No	List:

Please turn over

Medical Problems? Please explain below: Height:_____ Weight:_____

Heart disease	Yes No	
High blood pressure	Yes No	
Diabetes	Yes No	
Thyroid problems	Yes No	
High cholesterol	Yes No	
Dry eyes/ Eye problems	Yes No	
Heart murmur	Yes No	
Stomach problems	Yes No	
Liver problems	Yes No	
Respiratory problems	Yes No	
Arthritis	Yes No	
Seizures or epilepsy	Yes No	
Blood disorders	Yes No	
Cancer	Yes No	
Other	Yes No	
Wear glasses?	Yes No	
Hearing problems?	Yes No	

Do you have any of the following symptoms **now**?

□ Fever	□ Weight loss	□ Fatigue	□ Visual disturbance
□ Hearing loss	□ Nasal congestion	□ Sore throat	□ Hoarseness
□ Cough	□ Shortness of breath	□ Chest pain	□ Abdominal pain
□ Pain upon urination	□ Muscle/Joint pain	□ Rash	□ Weakness
□ Numbness	□ Breast pain	□ Nipple discharge	□ Swollen/warm breast

Pharmacy:_____

Do you have any cultural/religious practices that may affect your treatment? □Yes □No
If so, what:_____

What is your present occupation?_____

I certify that the above information is complete and accurate.

Patient signature:_____ Date:_____

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Patient Name:_____ D.O.B_____

Family History of Cancer (this includes grandparents, parents, uncles, aunts, siblings, cousins, children, nieces, nephews and grandchildren)

☐ Unknown/Adopted ☐ None

Relationship	Maternal/Paternal	Age at Diagnosis	Type of Cancer	Alive?	Died from Cancer?

Gynecologic History

How old were you when you had your first period? _____

When was your last period? _____

At what age did you go through menopause? _____

How many times were you pregnant? _____

How many children do you have? _____

Have you ever had a miscarriage or abortion? _____

How old were you when your first child was born? _____

Did you breast feed?/For how long? _____

Have you ever taken hormone replacement therapy (for menopause)?/For how long?

_____

Have you ever taken birth control?/For how long? _____

When was your last mammogram?/Was it normal? _____

Have you ever had an abnormal mammogram? _____

When was your last Pap smear?/Was it normal?_____

Have you ever had an abnormal Pap smear? _____

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CENTER FOR
COMPREHENSIVE BREAST CARE

Two Capital Way
Suite 505
Pennington, New Jersey 08534
609 537 6700
609 537 6717 Fax
capitalhealth.org

PHOTOGRAPHIC IMAGING RELEASE

I, _____ agree that Lisa R. Allen, MD, or designated representatives of the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Lisa R. Allen, MD.

Signature:_____

Today's Date:_____

I fully and specifically grant my permission for the use of photographs, videotapes, or case information for the following purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Lisa R. Allen, MD to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed:

_____ My surgeon's office patient education materials
_____ My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office.
_____ My surgeon's web site or web page
_____ Lectures and multimedia presentations given by my surgeon for educational purposes.

Signature:_____

Printed name:_____

Today's Date:_____

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In an effort to avoid any misunderstanding, please note the following:

Please know your Insurance Benefits.

Many insurance plans have complicated rules regarding Specialist Visits and referrals. Even within the same insurance company, policies and procedures may vary from one plan to the next. As a result, it is impossible for our office to know the details of every patient's insurance plan.

If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physicians. If you have not received an authorization prior to your arrival it is your responsibility to contact your physician or insurance company. Please also note that if your specialist requires more visits that you insurer approves or if the referral has expired, you must contact you primary care physician for another referral. If you are unable to obtain the authorization, you may be asked to reschedule your appointment or you will be responsible for any charges incurred for that visit.

Some insurance companies will send the patient/subscriber payment(s) to the patient for services rendered. You are responsible for forwarding these payments to the physician. Any payments held will result in collection efforts.

I have read and understand the information above and agree that regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Patient Signature: _____ Date:_____

Capital Health

General & Financial Consent: Inpatient, Outpatient, Emergency Department

Financial Agreement: I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. I intend to be legally bound, assume full responsibility for, and agree to pay Capital Health upon presentation of the bill, all expenses, and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release: I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

Release of Information: I assign benefits payable for hospital and physicians' services to the physician or provider furnishing the service and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health is required by various governmental agencies to review and release patient information. Capital Health also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information.

I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during my treatment may be retained, preserved, used for teaching purposes, or disposed by Capital Health.

Consent to Release Medical Records: I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up care, this includes the designated Caregiver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and or HIV, AIDS diagnosis, treatment, or testing. I may revoke this authorization as it relates to Specially Protected Health Information by providing written notice to Capital Health, Health Information Management Department.

Consent for Blood Test: In the event a physician, hospital employee, worker, student, or other person is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids in connection with my treatment at Capital Health or during the discharge process, I consent to having my blood drawn and tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS), Hepatitis B virus, and Hepatitis C virus. Such testing will allow any necessary treatment of the physician, hospital employee, worker, student, or other person to begin without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker, student, or other person as required by law or as agreed to by me.

Information about Doctors at Capital Health: Some physicians and other health care providers who participate in your care, including but not limited to, for example, surgeons, radiologists, anesthesiologists, pathologists, pediatricians, and consultants are private practitioners and not employees or agents of Capital Health. Physicians who practice at Capital Health must meet certain educational and experience requirements; however, Capital Health is not responsible for specific care provided to you by that physician. If you wish to change your physician, ask to speak with a nurse manager.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Contact by Telephone, Cellular, and/or Electronic Communications: By signing this form you consent to the terms in this section. Capital Health conducts patient care quality reviews to ensure the continued highest quality of services. Patients may participate or be invited to participate in the surveys through the use of text messaging, phone call, automatic telephone dialing system, artificial, prerecorded voice messaging, or electronic mail. These communications may come from Capital Health or a third party vendor to the phone number or email address that the patients have provided. Patients are not required to provide a phone number or email address as a condition of receiving treatment and/or other healthcare service from Capital Health. Should you choose to opt out of receiving contact from Capital Health or its third party vendor, you understand that it is your responsibility to contact Capital Health Patient Experience Department at 1-609-394-6336 (RMC) or 1-609-303-4280 (Hopewell) with this information. Message and data rates may apply.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Treatment: I consent to be treated by/admitted to Capital Health under the care of my physician, and their associates, partners, assistants, and designees. I consent to any hospital care, which encompasses routine laboratory, diagnostic, or medical/surgical treatment advisable during treatment and or hospitalization. I agree to allow medical students, interns, and residents, under the supervision and direction of a physician to observe my treatment and review my medical record. I understand that no guarantees have been made to me about the outcome of this care. I acknowledge that Capital Health has the authority to dispose of specimens taken for laboratory and pathology examinations.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Interoperability – Admission, Discharge and Transfer Notifications

In accordance with the Interoperability and Patient Access final rule (CMS-9115-F) Capital Health is required to make Conditions of Participation (CoPs) for hospitals. CoPs require Capital Health sends electronic patient event notifications of patient's Admission, Discharge, and/or Transfer to another healthcare facility, or to another community provider or practitioner. Government regulations require Capital Health to notify your primary care physician, referring physician, or other community provider in the event that you are admitted, discharged, or transferred to another facility.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Acknowledgement of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy:

☐ **By checking this box, I confirm that I have received the Capital Health Notice of Privacy Practices. The act of checking this box shall have the same effect as signing my name.**

By signing below, I agree to be subject to all of the terms in this General and Financial Consent. I agree that any checked boxes shall have the effect of my written signature.

X _____ Relationship to Patient: _____ Date: _____Time: _____
(Signature of patient or patient representative)

Witness: _____ Date: _____ Time: _____

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

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Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call your office. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

Missed Appointment Fees

- Patients who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and subsequent missed appointment: **$25 fee billed to your account**
- Third missed appointment: **Possible discharge from our practice**

Patient Name: _____

Patient's Signature: _____ Date: _____