

MR#: \_\_\_\_\_

CAROLINA BREAST & ONCOLOGIC SURGERY  
2223 Hemby Lane, Greenville, NC 27834 (252)413-0036  
**DEMOGRAPHIC INFORMATION**  
*All information is strictly confidential*

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

SS#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Best Time, Place to reach you: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Referring Doctor / Name / Location / Phone Number: \_\_\_\_\_

Pharmacy Name / Location / Phone Number: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**In Case of Emergency, Please Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**(Please Remember to Complete the BACK portion of this form as well)**

## 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. The above-named physician 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 and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

\_\_\_\_\_  
Signature of Patient, Beneficiary, Guardian or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient, Beneficiary, Guardian or Representative

\_\_\_\_\_  
Relationship to Beneficiary

## Medicare/Medigap Authorization

Medicare Number: \_\_\_\_\_

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to the healthcare providers at CAROLINA BREAST & ONCOLOGIC SURGERY for any services furnished to me by those providers. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medigap Services, my Medigap insurer, and their agents any information needed to determine those benefits or benefits for related services.

\_\_\_\_\_  
Signature of Patient, Beneficiary, Guardian or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient, Beneficiary, Guardian or Representative

\_\_\_\_\_  
Relationship to Beneficiary

## Authorization for the Use/Release of Health Information

From time to time, patient's family, friends or relatives call this 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 yourself, the patient. If you want the staff to be able to talk to anyone other than yourself about anything regarding your health care, please list the person or persons below:


I understand that Carolina Breast & Oncologic Surgery assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Carolina Breast & Oncologic Surgery from all legal responsibility that may arise from this authorization.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH HISTORY**

MR# \_\_\_\_\_

*All information is strictly confidential*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**SYMPTOMS:** *Please check only the symptoms you CURRENTLY have*

<b>General:</b>	<b>Eyes, Ear, Nose, Mouth, Throat, Neck:</b>	<b>Cardiovascular:</b>	<b>Genitourinary:</b>	<b>Psychologic:</b>
<input type="checkbox"/> No appetite	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chill	<input type="checkbox"/> Double vision	<input type="checkbox"/> Leg/ankle swelling	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Depressed mood
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Fever	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> No bladder control	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ear discharge		<input type="checkbox"/> Testicular mass	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Sweats	<input type="checkbox"/> Gum problem			
	<input type="checkbox"/> Hoarse voice	<b>Gastrointestinal:</b>	<b>Muscle/Joints:</b>	<b>Endocrine:</b>
<b>Skin:</b>	<input type="checkbox"/> Snoring	<input type="checkbox"/> Bloating	<input type="checkbox"/> Joint pain/ache	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bruises	<input type="checkbox"/> Neck mass	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Itching	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Bowel habit changes	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Rash/hives		<input type="checkbox"/> Constipation		<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Changing moles		<input type="checkbox"/> Difficulty swallowing		
		<input type="checkbox"/> Hemorrhoids		
<b>Head:</b>	<b>Lung:</b>	<input type="checkbox"/> Heartburn/Indigestion	<b>Neurologic:</b>	<b>Hematologic:</b>
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Nausea	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Bleeding problems
<input type="checkbox"/> Fainting	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Headache	<input type="checkbox"/> coughing blood		<input type="checkbox"/> Numbness	<input type="checkbox"/> Lymph node swelling

**WOMEN only:** Date of Last Menstrual Period: \_\_\_\_\_ Number of children: \_\_\_\_\_ Contraceptives/HRT: \_\_\_\_\_  
 Age at First Menstrual Cycle: \_\_\_\_\_ Age at First Live Birth: \_\_\_\_\_

**MEDICAL CONDITIONS** *Please check conditions you HAVE or HAD in the past:*

<input type="checkbox"/> Heart disease	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Psychiatric problem
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Goiter	<input type="checkbox"/> Migraines	<input type="checkbox"/> Anxiety disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> COPD/emphysema	<input type="checkbox"/> Anemia	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Depression
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hepatitis A, B or C

**CANCER (List):**

**SURGERIES (List):**

**CURRENT MEDICATIONS (List all medications and the doses you are currently taking)**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES (List all allergies to medications you may have):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY (Please answer the questions below):**

Do you smoke? Y N Packs per day? # years: \_\_\_\_\_

Do you drink alcohol? Y N Drinks per day? Per week? \_\_\_\_\_

Do you drink caffeine? Y N \_\_\_\_\_

Occupation: \_\_\_\_\_

(Please remember to complete the BACK portion of this form as well)

**FAMILY HISTORY (Please check any conditions that run in your family):**

<input type="checkbox"/> Heart disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Stones
<b>Cancer: (please note relation and age):</b>		
<input type="checkbox"/> Breast:		
<input type="checkbox"/> Colon:		
<input type="checkbox"/> Ovarian:		
<input type="checkbox"/> Uterine:		
<input type="checkbox"/> Other:		

**FALL HISTORY:**

Have you accidentally (unintentionally, suddenly) FALLEN in the last year? Yes\_\_\_\_ No \_\_\_\_

If yes, how many times did you fall? \_\_\_\_\_

**ADVANCE CARE PLAN:**

Do you have an Advance Care Directive (DNR, DO Not Resuscitate or a 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?

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**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

\_\_\_\_\_  
Date

# Patient Acknowledgement and Understanding of Carolina Breast & Oncologic Surgery's Privacy Practice

Patient's Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that Carolina Breast & Oncologic Surgery works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

Under the terms of this consent, I can ask Carolina Breast & Oncologic Surgery to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Carolina Breast & Oncologic Surgery does not have to agree to my request. If CBOS does agree to my request, I understand that would follow the agreed limits as outlined in the Privacy Policy.

I may cancel this consent in writing at any time by doing the following:

1. Signing and dating a form that CBOS can give me call "Revocation of Consent for us and Disclosure of Health Care Information"; or
2. Writing, signing and dating a letter to CBOS. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care options.

If I revoke this consent, CBOS does not have to provide further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of CBOS "Notice of Privacy Practices." My signature means that I agree to allow CBOS to use and disclose the patient's personal health information to carry out treatment, payment and health care operations.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc.)

\_\_\_\_\_  
Refusal to sign (signed by staff with reason)

I request that health plan benefits be made on my behalf to CBOS for any service furnished to me. I authorize CBOS to release to the respective health plans and its agents any information needed to determine these benefits payable for related services.

I understand that I remain financially responsible to CBOS for any and all charges not covered by insurance. Patients of contracted payers may be responsible for payment as directed by the insurance company, as the patient's responsibility.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date