BREAST CENTER
OF NAPLES

PATIENT HISTORY FORM

Name: _____ Date:_____ DOB: _____
Height: _____ Weight: _____

Referring Doctor: _____ If you would like to have your breast imaging report sent to any other doctor(s) please list them here: _____

Is this your first mammogram? YES NO If no, when and where was your last mammogram performed?

Do you have breast implants? YES NO

Reason for today's exam (select one):
____ Screening, no known current breast problems
____ Current breast problem (indicate all options that apply):

___ Lump or thickening
___ Bloody nipple discharge
___ Non-bloody discharge
___ Breast Implant problem
___ Nipple abnormality
___ Follow-up from prior abnormal mammogram

Personal History
Have you had a breast biopsy for something that was not cancer (benign)? YES NO

Have you ever had breast cancer? YES NO If yes, Type? _____ Side?_____ Age at Diagnosis?_____

Have you ever had other cancer? YES NO If yes, Type? _____ Age at Diagnosis?_____

Family History
List family members, by relationship, who have had **breast** cancer and at what age they were diagnosed:

PRIMARY FAMILY (Mother, Father, Sister, Daughter, etc.)	YOUR MOTHER'S SIDE (Grandparent, Aunt, Cousin)	YOUR FATHER'S SIDE (Grandparent, Aunt, Cousin)
_____Age _____	_____Age _____	_____Age _____
_____Age _____	_____Age _____	_____Age _____
_____Age _____	_____Age _____	_____Age _____

List family members, by relationship, who have had **ovarian** cancer and at what age they were diagnosed:

PRIMARY FAMILY (Mother, Sister, Daughter)	YOUR MOTHER'S SIDE (Grandmother, Aunt, Cousin)	YOUR FATHER'S SIDE (Grandmother, Aunt, Cousin)
_____Age _____	_____Age _____	_____Age _____
_____Age _____	_____Age _____	_____Age _____

Have you or anyone in your family had a blood test for a breast cancer gene? YES NO If yes, how are they related to you and what were the results? _____

Medical History

Age at first period: _____
Date of last period: _____
# of Pregnancies: _____
# of Deliveries: _____
Age at first pregnancy: _____

Age at Menopause: _____
Do you have any Ashkenazi Jewish Heritage? YES NO
Are you pregnant? YES NO
Hysterectomy? _____
Ovary(ies) Removed? _____

Total Relatives

Sisters _____
Daughters _____
Maternal Half Sisters _____
Paternal Half Sisters _____
Maternal Aunts _____
Paternal Aunts _____

Contraceptive use within the LAST YEAR:
Oral YES NO
IUD YES NO

Hormone Replacement Therapy
Type? _____
How long? _____ Currently using? _____

Have you had any breast procedures? If yes, please indicate the date and side of any of the following: **Mastectomy, Lumpectomy, Excisional Biopsy, Biopsy, Radiation Therapy, Breast Implants, Breast Reduction or Lift**

Procedure	Side	Date	Result if biopsy (benign or malignant)

BREAST CENTER
OF NAPLES

Patient Information

Last Name: _____ First Name: _____ MI: _____

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

DOB: _____ Gender: ☐ Female ☐ Male Email: _____

Phone: _____ Is it okay to leave a message? ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Policy # _____ Group # _____

Policy Holder's Name: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy # _____ Group # _____

Policy Holder's Name: _____ Policy # _____ Group # _____

_____ _____

Signature of Patient/Patient's Legal Representative Date

_____

Printed Name of Patient/Patient's Legal Representative

BREAST CENTER
OF NAPLES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO CERTAIN PERSONS

I authorize Breast Center of Naples to furnish my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care. This agreement is in effect until otherwise revoked in writing by the Patient/Personal Representative.

Name _____ Phone # _____

Name _____ Phone # _____

Signature of Patient/Guardian_____ **Date** _____

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Breast Center of Naples, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

Signature of Patient/Guardian _____ **Date**_____

BREAST CENTER
OF NAPLES

FINANCIAL POLICY AND AUTHORIZATION FOR INFORMATION RELEASE

Below is a statement of our financial policy. Please review and sign where indicated. Thank you for choosing Breast Center of Naples for your care.

INSURANCE AND PAYMENT POLICY

Your insurance policy is a contract between you and your insurance company. It is important that you contact your insurance company prior to your visit to assure that we are a participating provider. Your insurance company will also be able to inform you if a referral is required or if precertification is needed prior to services being rendered. It is your responsibility to determine if services will be covered and if your deductible has been met.

We will bill most insurance carriers for you if proper information has been provided to us. If payment has not been made by the insurance company within 60 days, the unpaid balance will become your responsibility. All outstanding patient balances over 120 days from the original date of service without payment arrangements may be turned over to a collection agency. If Medicare is your primary insurance, we will file all claims and accept assignment for related services.

Co-payments and/or deductibles are due at the time of service. We accept payment in the forms of cash, check, and major credit cards. There will be a $25 fee for all returned checks. Self-pay patients are required to pay at the time of service.

If you have any questions or concerns about billing, please call us at 239-238-1210.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Breast Center of Naples to furnish my protected health information to my insurance company concerning my illness and treatment for payment purposes. I hereby assign all benefits payable directly to Breast Center of Naples for services rendered. I understand that in the event my insurance denies this claim, I will be held financially responsible for all charges.

Patient Name _____ **DOB** _____

Signature of Patient/Guardian _____ **Date** _____

BREAST CENTER
OF NAPLES

Authorization For Release of Health Information

By signing below, I hereby authorize the RELEASE of my entire current and future breast imaging records to Breast Center of Naples. Should I need my imaging records sent to another facility for treatment purposes, I give Breast Center of Naples my permission to release my records.

Patient Name: _____ DOB: _____

Facility: _____ Dates of Imaging: _____

We are requesting **ALL PREVIOUS MAMMOGRAPHY STUDIES/BREAST RELATED IMAGING AND REPORTS** on the above patient to be used for comparison. Please send a CD in DICOM format and reports to the following:

Breast Center of Naples
3555 Kraft Road, Suite 350
Naples FL 34105

Phone: (239) 238-1210 Fax: (239) 238-1212

* I understand that I have the right to revoke this Authorization at any time in writing, except to the extent that Breast Center of Naples has already acted in reliance on this Authorization.
* I understand that Breast Center of Naples may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.
* This Authorization shall be effective for three years or until I revoke it in writing.

_____ _____
Signature of Patient /Authorized Representative Date

_____
Printed Name

BREAST CENTER
OF NAPLES

Patient Acknowledgement
Appointment Cancellation Policy

Breast Center of Naples has instituted an **Appointment Cancellation Policy**. A cancellation or no show made without any notice significantly limits our ability to make the appointment available for another patient. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

- Please contact our office in the event that you need to cancel or reschedule your appointment. You can call our office at (239) 238-1210 during normal business hours or leave a message after hours with our answering service.
- **A "NO SHOW", "NO CALL" or missed appointment will be assessed a $50.00 fee.**
- This fee is not billable to your insurance.
- As a courtesy, we make reminder phone calls, for appointments, one to two days in advance. We also send out text reminders, if you have opted in to this service.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer any questions you have. We will provide a copy of this policy to you, if requested. Please sign and date below with your acknowledgement.

I have read and understand the Appointment Cancellation Policy and acknowledge the terms. I also understand and agree that such terms can be amended from time-to-time by Breast Center of Naples.

_____ _____

SIGNATURE **DATE**

BREAST CENTER
OF NAPLES

Bone Density Questionnaire

Name: _____

Sex: _____

Current Height: (in) _____

Weight: (lb) _____

Menopause Age: _____

1. **Have you had a previous hip or vertebral fracture?** Yes ____ No ____
2. **Have you had hip surgery or spinal surgery?** Yes ____ No ____

   If so, type of surgery _____
3. **Have you had any fractures during your adult life which did not result from significant trauma?** Yes ____ No ____
4. **Did either of your parents ever have a hip fracture?** Yes ____ No ____
5. **Do you smoke?** Yes ____ No ____
6. **Have you ever taken Glucocorticoids?** Yes ____ No ____
7. **Do you have rheumatoid arthritis?** Yes ____ No ____
8. **Do you have secondary osteoporosis?** Yes ____ No ____
9. **Do you drink 3 or more alcoholic beverages per day?** Yes ____ No ____
10. **Are you being treated for osteoporosis?** Yes ____ No ____
11. **Have you ever taken any medications for osteoporosis?** Yes ____ No ____

    If so, name of medication _____
12. **Do you have hyperparathyroidism?** Yes ____ No ____