



REGISTRATION FORM

Date _____

Section I: Patient Information

Last Name: _____ First Name: _____ Preferred Name: _____

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



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 Medical 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 _____

Age at first birth _____

Last menstrual period _____

Years on birth control _____

Age at menopause _____

Years on hormone replacement _____

Number of pregnancies _____

Months breastfeeding _____

Number of live births _____

History of radiation to chest _____

History of breast biopsy _____

Race/Ethnicity (Please circle)

****This information is used to calculate statistical risk****

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 hereby give The Breast Place and any other associated provider consent for medical treatment.
_____ Initial

2. **RELEASE OF INFORMATION:** I, the below named patient, do hereby 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 the initial visit, our billing department will contact the insurance company to verify coverage and benefits for the procedure. Copays, co-insurance, and deductibles **are due prior to any 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

Any overpayment made by the patient will first be applied to any past due balance (if applicable) for that patient's account. An overpayment less than \$10 will be held on the account for future visits unless otherwise requested. If there is an overpayment on an account, a refund will be processed 14-28 days after final insurance payments and/or adjustments are applied to the charges resulting in the overpayment.

_____Initial

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 patients meet 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

Late Arrivals: We are able to accommodate patients up to 15 minutes past their appointment time. All paperwork and registration must be completed within 15 minutes of your scheduled start time in order for the doctor to see you for your appointment. If you have not arrived and completed your paperwork in time you may be rescheduled to another date and time.

Missed Appointments: There will be a \$25.00 charge for missed appointments without a 24 hour notice. A \$100.00 charge will be applied for surgery no shows 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. Unfortunately, our providers cannot discuss financial matters with you.

I understand the above financial policy and my responsibility.

The Breast Place billing phone number: 843-797-1941, ext 207

Patient Signature: _____

Print Name: _____

Date: _____



THE BREAST PLACE

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

4975 Lacross Road Suite 110

North Charleston, SC 29406

843-797-1941 Phone

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

4975 Lacross Road Suite 110

North 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