Patient Registration Form

Date:_____

Name:_____DOB:_____Age:_____
Height:_____Weight:_____Current Bra Size:_____
Referred By:_____

Reason for visit:_____

Yes or No

Y **N** Can you feel lumps in your breast now? How and when did you discover this?
_____

Y **N** Have you had a mammogram previously?
Where?_____When?_____

Y **N** Have you previously had a Bone Density test performed? If so, When?_____

Y **N** Have you had any nipple discharge? If so which nipple? **R**ight or **L**eft_____

Y **N** Have you experienced pain, discomfort, or soreness?
If so, how long?_____

Y **N** Have you had any injury to the area?
If so, when and how?_____

Y **N** Previous breast surgery? **R**ight__**L**eft____When:_____Physician:_____

Y **N** Aspiration with needle? **R**ight__**L**eft____When:_____Physician:_____

Y **N** Biopsy? **R**ight__**L**eft____When:_____Physician:_____

Y **N** Mastectomy? **R**ight__**L**eft____When:_____Physician:_____

Y **N** Breast Implant? **R**ight__**L**eft____When:_____Physician:_____
Are your implants Silicone / Saline ?

Y **N** Breast Reduction? **R**ight__**L**eft____When:_____Physician:_____

Y **N** Lumpectomy for **Cancer**?**R**ight__**L**eft____When:_____Physician:_____

Y **N** **Family History of Breast, Ovarian, Uterine, Prostate, Colon Cancer, or Melanoma?**

	Who?	Age at diagnosis?	Type of Cancer
☐	Self		
☐	Grandmother		
☐	Mother		
☐	Sister		
☐	Aunt		
☐	Daughter		
☐	Father		

Y **N** DO YOU PRACTICE SELF EXAMS? If yes, how often?_____

Menstrual History

Y **N** Do you menstruate? Age at first period___ Beginning date of last period:_____

Y **N** If you do not menstruate, approximate date of your last period:_____

Y **N** Have you had a hysterectomy? If yes, when?_____Why?_____

Y **N** Have your ovaries been removed? If yes, when?_____Why?_____

Y **N** Is there a possibility you are pregnant?

Hormone History (birth control pills, estrogen, progesterone, thyroid, or cortisone)

Y **N** Have you ever taken any form of the hormones listed above?
If yes, which type, how long have you taken it, and date of last dose:_____

_____

Y **N** Do you have any biological children?
How many pregnancies have you had?_____Live Births:_____
Age at first pregnancy:_____Age at last pregnancy:_____

Y **N** Did you breast feed? If yes, how long with each child?_____

Medical History

Y **N** Do you have any drug allergies? Please list ALL allergies and your reactions
Please also include allergies to adhesives, latex, soaps, etc.):_____

_____

_____

_____

Y **N** Do you have history of Tuberculosis (TB)?

Y **N** Have you had any other surgeries besides the breasts? Please list when and why:

_____

_____

_____

_____

Y **N** Have you ever had problems with anesthesia? Please Explain:_____

_____

Y **N** Do you need to take antibiotics prior to surgery or dental procedures? Why:

_____

Y **N** Do you have any chronic conditions? If yes, **please circle** all that apply:
Diabetes Type__, Heart Condition, Bleeding Disorder, Asthma,
High Blood Pressure, Mitral Valve Prolapse, Sleep Apnea, etc.
Please explain:_____

_____

_____

Y **N** Have you EVER been diagnosed with ANY communicable disease
(**HIV, Hepatitis C**, etc.)? If so, what ?_____

Y **N** Do you require the use of an insulin pump?

Y **N** Do you require the use of a C-Pap machine?

Y **N** Do you have a pacemaker? If so, what is the contact number on your
card in case of diagnostic procedure interference?_____

Social History

Y **N** Do you smoke or have you ever smoked? If yes, how much daily:_____
How many years have been a smoker?_____

Y **N** Do you drink alcohol? If yes, how often?_____

Y **N** Do you drink caffeinated drinks or eat chocolate? How much daily?
Coffee:_____Tea:_____Soft Drinks:_____Chocolate:_____

Physician History

Who is your referring physician?_____

To better coordinate your care please provide a list of your current physicians and their contact information.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Information

Pharmacy name:_____ Phone number:_____

Current Medications

Please list the current medications you are taking including herbal supplements and vitamins. Please also note the dosage, how many times of day, and why you take the medication.

Medication Name	Dose	Times Daily	Reason

Patient Signature:_____ **Date:**_____

Thank you for taking the time to fill out this request,
it is truly a helpful tool in giving you the best treatment possible!
Thanks Again!

Patient Information

NAME _____ DATE OF BIRTH _____

ADDRESS _____ COUNTY _____

CITY _____ STATE _____ ZIP _____

HOME # _____ CELL _____ WORK _____

E-MAIL _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

WORK ADDRESS _____

SOCIAL SECURITY # _____ SPOUSE SSN _____

SPOUSE _____ SPOUSE DOB _____

CELL PHONE _____ WORK _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

EMERGENCY CONTACT _____ PHONE _____

PRIMARY INSURANCE _____ DEDUCTABLE _____

POLICY/I.D. # _____ GROUP # _____

EMPLOYER'S NAME _____ CARD HOLDER _____

INSURANCE ADDRESS _____ PHONE _____

SECONDARY INSURANCE _____ DEDUCTABLE _____

POLICY/I.D. # _____ GROUP # _____

EMPLOYER'S NAME _____ CARD HOLDER _____

INSURANCE ADDRESS _____ PHONE _____

I understand I am responsible for all fees, regardless of insurance coverage which may include co-pays, deductibles, or co-insurance. I assign insurance payments directly to the doctor. I authorize the office to release all information necessary to secure the payment of benefits of insurance. This authorization renews annually.

I authorize the Breast Care Center of Indiana, P.C. to obtain any available pathology slides, x-ray films, and reports of my medical care.

SIGNATURE OF PATIENT/GUARDIAN	SIGNATUE OF INSURED IF OTHER THAN PATIENT	DATE