Here is a checklist of what you will need to bring to your initial visit. Your provider needs to have all of the following medical information and imaging in hand at your time of visit, in order to provide you with the best care possible. If your clinical information or films are missing, your appointment will need to be rescheduled. Please read each item carefully, and call the office with any questions or concerns.

1-The attached forms:
   Please complete the following pages as best you can. We will be glad to assist you with any items you may have questions about. If you prefer to complete the forms in the office at the time of your visit, please arrive AT LEAST 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME, so that you will have ample time to complete these forms and register.

2-Your mammogram, ultrasound, and MRI films:
   Please bring any current mammograms, breast ultrasounds and breast MRI imaging!

   **THIS IS EXTREMELY IMPORTANT:** We allow ultrasounds and MRI imaging on a CD. However, mammograms must be printed on physical film strips, because the resolution on a standard computer is not sufficient to see subtle mammogram findings.

   Please bring as many mammograms, breast ultrasounds, MRIs, and any other breast film studies as you can. **THREE YEARS of imaging should be sufficient.** The more prior years you can bring the better. It is very important that your provider sees the same imaging the radiologists have seen. If you are unsure of which films to bring, please give the office a call and we will gladly assist you.

   You will need to call your imaging center in advance to have your films prepared for pickup. The more notice you provide the imaging center, the better your chances are of getting everything you need. Also, since many films are stored digitally, you must BE VERY EXPLICIT in telling your imaging center to print 3 years of mammograms or else they will only supply you with a single year, which is insufficient.

   Do NOT plan on picking up your films on the way to your appointment, as experience on our end proves that this rarely goes as planned. We would hate to inconvenience all parties involved by having to reschedule your appointment.

   **BEFORE YOU LEAVE THE IMAGING CENTER,** you will need to **look at the contents of the film jacket with the imaging center staff,** to make sure the current and prior years’ films are actually in the film jacket, along with the typed radiologists’ reports. It is unfortunate, but too frequently there are missing x-ray studies, even when the patient has called ahead with their imaging request and the omission of films is not realized until you have arrived at the office, and thus resulting in the appointment being rescheduled for a later date.

   Lastly, it is a common misunderstanding on the part of patients, that their referring physician, or the imaging center, has sent their actual films to our office in advance. We receive written reports from these sources to help us plan the appropriate timing and length of your visit, but **WE DO NOT RECEIVE FILMS VIA MAIL OR FAX.** If you are uncertain if we already have your films in our office, please call us before your appointment for clarification.

3- Your insurance card.
   If you do not have health insurance, please contact us prior to your appointment date, so we can accommodate you with mutually acceptable arrangements.

4-Photo I.D.

5-Written referral note from your primary care physician, IF REQUIRED by your insurance.

6-Copayments. Credit cards, checks, and cash are all acceptable methods of payment.
# Patient Registration Form

## PATIENT INFORMATION

- Dr. □ Mr. □ Mrs. □ Ms. □ Jr. □ Sr. □ Other □
- Patient’s Name (Last) ______________________  □  □  □  □
- (First) ______________________  □  □  □  □
- (Middle) ______________________  □  □  □  □
- Also Known As Name (Last) ______________________  □  □  □  □
- (First) ______________________  □  □  □  □
- Marital Status □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Other □
- Social Security Number ___________  □  □  □
- Female □ Male □ Date of Birth _______ / _______ / _______
- E-Mail Address ______________________  □  □  □  □
- Phone Numbers Work ___________  □  □  □  □
- Day □ Evening □ Home ___________  □  □  □  □
- Day □ Evening □ Cellular ___________  □  □  □  □
- Pager ___________  □  □  □  □
- Address ______________________  □  □  □  □
- City, State, ZIP (+4) ______________________  □  □  □  □
- Employment Status □ Employed □ Full-Time Student □ Part-Time Student □ Retired □ Self-Employed □ Unemployed □
- Employer ______________________  □  □  □  □
- Occupation ______________________  □  □  □  □
- Emergency Contact Name ______________________  □  □  □  □
- Phone Number ______________________  □  □  □  □
- Emergency Contact Relationship to Patient ______________________  □  □  □  □
- Referring Provider Name ______________________  □  □  □  □

## RESPONSIBLE PARTY INFORMATION

- Responsible Party Name (Last) ______________________  □  □  □  □
- (First) ______________________  □  □  □  □
- (Middle) ______________________  □  □  □  □
- Also Known As Name (Last) ______________________  □  □  □  □
- (First) ______________________  □  □  □  □
- Social Security Number ___________  □  □  □
- Female □ Male □ Date of Birth _______ / _______ / _______
- E-Mail Address ______________________  □  □  □  □
- Phone Numbers Work ___________  □  □  □  □
- Day □ Evening □ Home ___________  □  □  □  □
- Day □ Evening □ Cellular ___________  □  □  □  □
- Pager ___________  □  □  □  □
- Address ______________________  □  □  □  □
- City, State, ZIP (+4) ______________________  □  □  □  □
- Employment Status □ Employed □ Full-Time Student □ Part-Time Student □ Retired □ Self-Employed □ Unemployed □
- Employer ______________________  □  □  □  □
- Employer Phone Number ______________________  □  □  □  □
- Patient Relationship to Responsible Party ______________________  □  □  □  □

## PRIMARY INSURANCE INFORMATION

- Name of Insured ______________________  □  □  □  □
- Insured Employer Name ______________________  □  □  □  □
- Insurance Company/Phone Number ______________________  □  □  □  □
- Subscriber ID (Policy Number) ______________________  □  □  □  □
- Group ID ______________________  □  □  □  □
- Copay Amount ______________________  □  □  □  □
- Effective Date ______________________  □  □  □  □
- Termination Date ______________________  □  □  □  □
- Female □ Male □
- Insured Date of Birth _______ / _______ / _______
- Insured’s Social Security Number ___________  □  □  □
- Insurance Company Address ______________________  □  □  □  □

## SECONDARY INSURANCE INFORMATION

- Name of Insured ______________________  □  □  □  □
- Insured Employer Name ______________________  □  □  □  □
- Insurance Company/Phone Number ______________________  □  □  □  □
- Subscriber ID (Policy Number) ______________________  □  □  □  □
- Group ID ______________________  □  □  □  □
- Copay Amount ______________________  □  □  □  □
- Effective Date ______________________  □  □  □  □
- Termination Date ______________________  □  □  □  □
- Female □ Male □
- Insured Date of Birth _______ / _______ / _______
- Insured’s Social Security Number ___________  □  □  □
- Insurance Company Address ______________________  □  □  □  □

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ______________________  □  □  □  □
- Date ______________________  □  □  □  □
Reston Breast Care Specialists Patient HIPAA Acknowledgment and Consent Form

Patient Name: __________________________________________________________

Date of Birth: __________________________________________________________

______ (Patient initials) Notice of Privacy Practices. I acknowledge that I have received the practice’s Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice’s Notice of Privacy Practices.

______ (Patient initials) Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

   • Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.

   • If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

   • Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician’s office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

______ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

   Name: ____________________________________________________________ Date: ______________

   Name: ____________________________________________________________ Date: ______________

______ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

THE PHYSICIAN/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave message at home with my partner or:

   NAME: ____________________________________________________________ RELATIONSHIP: ______________________________

☐ Leave message on cell phone

   Cell phone number: ______________________________

☐ Leave message at work

   Work phone number: ______________________________

☐ Leave message voicemail

   Phone number: ______________________________

☐ Leave a detailed message on answering machine

   Phone number: ______________________________

Patient Signature: __________________________________________ Date: ______________

Patient Name (Printed): ___________________________ DOB: ____________________

Revised May 13, 2015
Reston Breast Care Specialists

Consent for Treatment and Payment Agreement

I hereby authorize Reston Breast Care Specialists to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accented laboratory tests, all of which in the judgement of the attending physicians or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Reston Breast Care Specialists’ benefits, otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee. I understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your copay and/or percentage which the insurance is not responsible for on the day of your visit. It is my responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the consent for treatment and payment policy above. I agree to forward Reston Breast Care Specialists all insurance or third party payments that I receive for services rendered to me immediately upon receipt. PATIENT INITIALS: __________

MEDICARE LIFETIME AUTHORIZATION

I certify that 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 information about myself to release to the Social Security Administration’s intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Reston Breast Care Specialists. PATIENT INITIALS: __________

I request this authorization also apply to all other insurance. PATIENT INITIALS: __________

I acknowledge that I was given Reston Breast Care Specialists Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. PATIENT INITIALS: __________

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and other listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information

<table>
<thead>
<tr>
<th>Release info (please circle)</th>
<th>Allowed in exam room (please circle)</th>
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*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature

Date ________________________ Patient Date of Birth ________________________
MEDICAL HISTORY FORM

NAME ___________________________ AGE _____ DATE OF BIRTH _____

DATE FORM COMPLETED ___________________________

PRIMARY CARE PHYSICIAN _______________________

OB/GYN _________________________

WHO REFERRED YOU? __________________________

PHARMACY INFORMATION

NAME ___________________________

ADDRESS _________________________

PHONE NUMBER _____________________

I. WHAT IS THE REASON FOR TODAY'S VISIT? (Please check all that apply)

____ I went for a routine visit, and my doctor felt a lump in ____my right ____my left ____both breast(s) and recommended follow-up.

____ I found a lump in ____my right ____my left ____both breast(s).
When did you first notice this? ________________________________

____ I went for routine exam, my breast exam was fine, and I was sent for mammogram which came back abnormal.

____ My mammogram shows a change when compared to my last mammogram.

____ I have pain in ____my right ____my left ____both breast(s).
Please describe: ____constant ____cycles ____same spot ____location varies
When did you first notice this? ________________________________

____ I have nipple discharge from ____my right ____my left ____both breast(s)
Color: __________________

When does this occur? ____spontaneously ____only when pressure is applied
____daily ____intermittently
When did you first notice the discharge? ________________________________

____ Other: (Please Specify) _________________________________

I examine my breasts ____monthly ____intermittently ____rarely ____never

II. CURRENT MEDICATIONS:

Please list your current PRESCRIPTION medicines/doses per day, and the reason for use:

Medicine/dose ___________________________ Reason for use: ___________________________

__________________________________________  _______________________________________

__________________________________________  _______________________________________

__________________________________________  _______________________________________
Please list any NON-Prescription drugs, herbs, or supplements currently used:

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<tr>
<th>Drug/Herb/Supplement Type</th>
<th>Reason for use</th>
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Are you taking daily aspirin therapy?  ____ No  ____ Yes

**III. MEDICAL HISTORY**

Please list your past medical illnesses:

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Have you ever had a blood transfusion?  ____ No  ____ Yes
When and Why? ______________________

Have you ever had any radiation treatments?  ____ No  ____ Yes

**IV. ALLERGIES/INTOLERANCE**

Are you allergic to, or sensitive to, LATEX or latex-containing items?  ____ No  ____ Yes
If yes, please describe reaction: _____________________________________________

Has your skin reacted badly to adhesives, tapes, band-aids, or sutures?  ____ No  ____ Yes

Please list DRUG allergies:  ____ None known

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<th>Drug</th>
<th>Type of Reaction</th>
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V. GYN HISTORY

Age periods started: ________________________________

Age at menopause, if applicable: ________________________________

Have you had a hysterectomy?
   ____ No
   ____ Yes, including removal of both ovaries
   ____ Yes, but one ovary, or a piece of ovary, was not removed.
   ____ Yes, but neither ovary was removed.
   ____ Yes, but I don’t know if my ovaries were removed.

   Age at hysterectomy ______
   Reason for hysterectomy: (Please check all that apply)
   ____ Abnormal bleeding
   ____ Endometriosis
   ____ Fibroids
   ____ Pelvic infections
   ____ Uterine cancer
   ____ Bladder problems
   ____ Pre-Cancer of Cervix
   ____ Cancer of Cervix
   ____ Pelvic Pain or Adhesions
   ____ Other Reason: ________________________________

Have you ever used estrogen replacement? (This does NOT includes vaginally inserted medicines or include oral contraceptives)  ____ No  ____ Yes

If yes, for how long?
   Less than one year ______
   1-5 years ______
   5-10 years ______
   10-15 years ______
   15+ years ______
   Are you using it currently? ____ No  ____ Yes
   If you no longer use it, when did you stop using? ________________________________

Estrogen replacement was being used for: (Please check all that apply)
   ____ to control bleeding
   ____ to control hot flashes
   ____ to control vaginal/pelvic pain
   ____ to control mood
   ____ to control sleep disturbance
   ____ to ease menopausal symptoms after hysterectomy
   ____ I am not sure
   ____ Other reason ________________________________

If using, please list your current hormone medication(s) and dose(s): ________________________________

Has the type or dose been changed recently?  ____ No  ____ Yes

Oral Contraceptive Use: Never used ______
   Less than one year ______
   1-5 years ______
   5-10 years ______
   10-15 years ______
   15+ years ______
   Are you using it currently? ____ No  ____ Yes
VI. OB HISTORY

Number of pregnancies: _________________________
Number of live births: _________________________
Age at first live birth: _________________________
Have you ever breast fed?  No  Yes
   If yes, number of children ________  total number of months ________

Have you ever taken fertility drugs?  No  Yes
   If yes, are you taking them now?  No  Yes

VII. SURGICAL HISTORY

Have you ever had: (Please check all that apply)
   _____ A cyst aspirated (fluid removed from the breast with a needle)  right  left
   _____ A breast biopsy (a piece of tissue or lump removed)  right  left
   ____________________________ Where was it done?
   ____________________________ When was it done?
   ____________________________ Results?

Do you have breast implants?  No  Yes

Please list other surgical procedures and dates:

   ____________________________
   ____________________________
   ____________________________

VIII. FAMILY HISTORY

   _____ There is no one in my family that I know of with a history of cancer.

My family history is positive for: (Please list relationship to you, and their approximate age at diagnosis)
(Include father's side)

Breast Cancer ____________________________
Ovarian Cancer ____________________________
Uterine Cancer ____________________________
Colon Cancer ____________________________
Other Cancer (do not include skin cancers that are not melanoma) ____________________________

Has any family member been tested for the “breast cancer gene” (BRCA 1 or 2 genes)?
   No  Yes  Don't know
IX. SOCIAL HISTORY/HABITS

Have you ever smoked? ___ No ___ Yes ___ If yes, how many packs per day? ___
For how long? ___________ years
If you are no longer smoking, how many years ago did you quit? ___________ years

How many alcoholic beverages do you consume weekly? _______

Some races/ethnic groups carry a higher incidence of breast cancer-related genes, which is why we ask you to identify your family origin: ___ Caucasian ___ Eastern European ___ Northern European ___ Western European ___ Native American ___ Caribbean ___ Middle Eastern ___ Asian ___ African American ___ Pacific Islander ___ Central/South American ___ Hispanic ___ Non-Hispanic ___ Ashkenazi (Eastern European Jewish) ___ Other: _______

X. REVIEW OF SYSTEMS (Please only check symptoms that you currently experience)

Constitutional Symptoms
___ Fever ___ Night sweats ___ Unexplained weight loss ___ Unexplained weight gain ___ Insomnia ___
___ Migratory Pain ___ Other ___

Eyes
___ Blindness ___ Cataracts ___ Glaucoma ___ Retina Problem ___ Other ___

Ears, Nose, Mouth, Throat
___ Dizziness ___ Ear Problems ___ Sinus Problems ___ Bleeding gums ___ Change in voice ___
___ Tooth problems ___ Nose Bleeds ___ Sore throat ___ Difficulty swallowing ___ Other ___

Cardiovascular
___ Heart disease ___ High blood pressure ___ Poor circulation ___ Chest Pain ___
___ Ankle swelling ___ Leg pain while walking ___ Rheumatic fever ___ Fast heart beat ___
___ Irregular heartbeat ___ Heart Attack ___ Other ___

Respiratory
___ Asthma ___ Chronic cough ___ Emphysema ___ Tuberculosis ___ Short of breath ___
___ Pneumonia ___ Sleep Apnea ___ Use CPAP or BIPAP ___ Other lung problems ___

Gastrointestinal
___ Difficulty swallowing ___ Gastritis ___ Hiatal hernia ___ Ulcers ___ Acid reflux ___ Polyps ___
___ Nausea/vomiting ___ Liver disease ___ Cirrhosis ___ Hemorrhoids ___ Hepatitis C ___ Constipation ___ Diarrhea ___
___ Irritable bowel ___ Bloody stools ___ Diverticulosis ___ Gluten intolerance/celiac disease ___ Other stomach or intestinal/colon problems ___

Urinary
___ Kidney stones ___ Kidney infection ___ Painful urination ___ Blood in urine ___ Urine leakage ___
___ Bladder infection ___ Low kidney function ___ Other kidney/bladder problem ___

Muscular/Skeletal
___ Arthritis ___ Osteoporosis ___ Neck Pain ___ Back pain ___ Fibromyalgia ___
___ Artificial joints ___ Disc problems ___ Other muscle/bone problems ___

Skin
___ Psoriasis ___ Eczema ___ Melanoma ___ Rashes ___ Other skin problems ___

Nervous System
___ Migraines ___ Slurred speech ___ Stroke/CVA ___ Mini-stroke/TIA ___
___ Seizures ___ Other brain or nerve problems ___

Psychiatric
___ Depression ___ Anxiety ___ Bipolar ___ Drug/Alcohol problem ___
___ Other psychiatric conditions ___

Endocrine
___ Diabetes ___ Hypoglycemia ___ Goiter/thyroid surgery ___ Low thyroid ___ Hyperthyroid ___
___ Other ___

Blood/Lymph Systems
___ Anemia ___ Easy bruising ___ Bleeding disorder ___ Blood clots/clotting disorder ___ Sickle cell disease/trait ___ Other blood or lymph gland problems ___

Allergy/Immune System/Infectious disease
___ Immune deficiency ___ Environmental allergies ___ HIV ___
___ Current allergy shots ___ History of MRSA ___ Other immune/allergy/infection problems ___

Any complaints not listed above? _______

Please list your: Height ft. inches Weight lbs. Bra Size _______

Thank you!!!