VIRGINIA BREAST CARE PLC
595 MARTHA JEFFERSON DR. - ST 320 - CHARLOTTESVILLE, VA 22911
Phone: (434) 984-6121 • Fax:

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.
I hereby assign, transfer, and set over to VIRGINIA BREAST CARE PLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree to pay any and all court costs, interest, legal fees, and collection agency fees in the amount of 33.3% of the total amount due, in the event my account is placed for collections.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

Virginia Breast Care

Dr. Linda M. Sommers ♦ Dr. John A. Jones

Chart # _____

Patient Name: _____

Referring Doctor: _____

Other doctor's you may want informed:_____

Reason for your visit today: _____

_____

_____

_____

What symptoms have you had related to this? _____

_____

_____

_____

_____

What special concerns do you have about this condition?_____

_____

PREVENTATIVE CARE:

	Date of Procedure	Location of Procedure
Mammogram		
Chest x-ray		
Electrocardiogram		
Blood tests		
Physical exam		
GYN exam		

Have you had any of the following symptoms?
If "Y", please indicate which breast and how long it has been present.

Breast Pain	___Y or N___	Right or Left	How Long?
Lump(s)	___Y or N___	Right or Left	How Long?
Nipple Discharge	___Y or N___	Right or Left	How Long?
Skin Changes	___Y or N___	Right or Left	How Long?
Abnormal Mammogram	___Y or N___	Right or Left	When?

PLEASE INDICATE ANY LUMPS, SYMPTOMS OR SCARS BY <u>DRAWING ON THE DIAGRAM</u> BELOW:

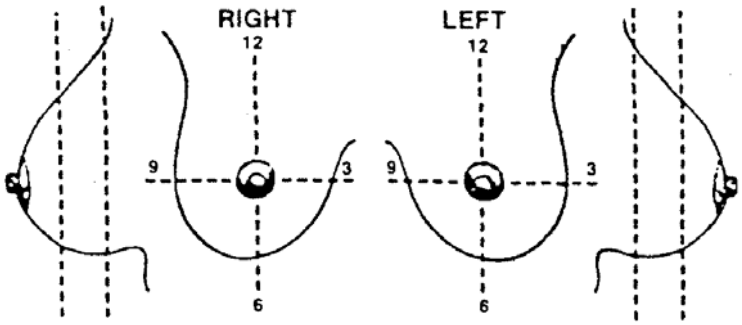

Chart # _____

MEDICATIONS: _____
_____

ALLERGIES:_____

CURRENT SYMPTOMS:

☐ Abdominal pain	☐ Blood in stool	☐ Blood in urine
☐ Breast lumps	☐ Change in bowel habits	☐ Change in vision
☐ Chest pain	☐ Cough	☐ Cramping in legs
☐ Fever-sweats	☐ Frequent urination	☐ Headaches
☐ Indigestion	☐ Irregular Menses	☐ Lumps or masses
☐ Nausea or vomiting	☐ Numbness or tingling	☐ Pain on urination
☐ Shortness of breath	☐ Skin changes	☐ Swelling of legs
☐ Vaginal discharge	☐ Weight loss	☐ Other: _____

Other Family History:

☐ Cancer	☐ Heart disease	☐ High blood pressure
☐ Diabetes	☐ Gallstones	☐ Stroke
☐ Other: _____		

SOCIAL HISTORY:

Marital Status: _____
Occupation: _____
Hobbies: _____

Are you sexually active?	YES	NO		
Do you currently smoke?	YES	NO	_____ PACKS / DAY	
Have you ever smoked?	YES	NO	If so: _____ PACKS / DAY	Date Quit: _____
Describe your alcohol usage:	NONE		OCCASIONAL	#DRINKS / DAY: _____
Do you use recreational drugs?	YES	NO		
Do you Exercise?	YES	NO	_____ # TIMES / WEEK	

Chart # _____

BREAST HISTORY AND RISK FACTORS

Have you ever had any breast surgery or needle biopsies? ·····	YES	NO	Right, Left or Both
If YES, is there any history of ATYPIA? ·····	YES	NO	
Is there any history of ATYPIA on breast biopsy? ·····	YES	NO	
What was the age of your first period? ·····	____	YEARS OLD	
Do you have children? ·····	YES	NO	
If YES, how many? ·····	_____		
If you have children, what was the age when you had the first child: ·····	____	YEARS OLD	
Did you breast feed the children? ·····	YES	NO	
Have you gone through Menopause? ·····	YES	NO	
Is there any history of taking hormone or birth control pills? ·····	YES	NO	
Is there any family history of BRCA1 BRCA2 gene? ·····	YES	NO	
Are you of Ashkenazi Jewish heritage? ·····	YES	NO	
Is there any history of chest or breast radiation? ·····	YES	NO	
Are you currently or possibly pregnant? ·····	YES	NO	

Family History of Breast Cancer:

	Mother	Sister	Daughter	Grandmother	Aunt	Cousin
Mother's Side	☐	☐	☐	☐	☐	☐
Father's Side	☐	☐	☐	☐	☐	☐

Family History of Ovarian Cancer:

	Mother	Sister	Daughter	Grandmother	Aunt	Cousin
Mother's Side	☐	☐	☐	☐	☐	☐
Father's Side	☐	☐	☐	☐	☐	☐

Are there any Males on EITHER side with a History of Breast Cancer? YES NO

YOUR MEDICAL HISTORY:

HAVE YOU HAD ANY OF THE FOLLOWING?

☐ AIDS-HIV	☐ Anemia	☐ Arthritis
☐ Asthma	☐ Bleeding problems	☐ Cancer
☐ Circulation problems	☐ Clots in veins	☐ Depression
☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ GERD	☐ Glaucoma	☐ Gout
☐ Gynecologic problems	☐ Heart disease	☐ High blood pressure
☐ Kidney problems	☐ Liver problems	☐ Lung problems
☐ Migraines	☐ Pancreatitis	☐ Parkinson's Disease
☐ Pneumonia	☐ Stomach problems	☐ Stroke
☐ Thyroid problems	☐ Ulcers	☐ Other: _____

PAST SURGICAL HISTORY:

☐ Appendectomy	☐ Hernia Surgery	☐ Tubal ligation
☐ Gallbladder	☐ Artery or vein	☐ Surgery
☐ Hysterectomy	☐ Tonsillectomy	☐ Breast Surgery
☐ Caesarian Section	☐ Intestinal Surgery	☐ Bone or joint Surgery
☐ Neck/Back Surgery	☐ Breast biopsy(needle or surgical)	☐ Other: _____
Other Surgery:		

VIRGINIA BREAST CARE

595 PETER JEFFERSON PARKWAY, SUITE 320

CHARLOTTESVILLE, VA 22911

434-984-6121

Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this consent form, you give us permission to use and disclose protected health information about you for treatment, payment and healthcare operations except for any restrictions specified below to which we have agreed. **Protected Health Information** is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you.

Our Notice of Privacy Practices provides protective health information about you. You have the right to receive a copy of our **Notice of Privacy Practices** before signing this consent form. If we change our notice, you may obtain a revised copy by contacting our office. We are available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request how protected health information about you is used or disclosed for treatment, payment or healthcare operations. **We are not required to agree to any restrictions but if we do, we are bound by our agreement.** If you wish to make a restriction please request a copy of our **Form to Request Restrictions.**

If you do not sign the Consent Form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this consent form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent. You may request to use our **Authorization for Release of Information** for the purposes of requesting your revocation, or you may simply send us a letter in writing.

Print Name:_____

Parent or Guardian, if patient is a minor:_____

Signature:_____ **Date:**_____