Barry J Roseman, M.D.

Advanced Breast Care
Surgical Oncology of North Georgia, Inc.

Confidential Medical History

Today's Date: _____

Name: _____ Age: _____ DOB: _____

Social Security Number: _____

Physical Address: _____

City, State, Zip Code: _____

Mailing Address (if different): _____

City, State, Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Marital Status: Married { } Divorced { } Single { } Separated { } Widowed { }

Spouse's Name: _____ Number of Children:: _____

Employer: _____

Address: _____

Phone: _____ Occupation: _____

Spouse's Employer: _____

Address: _____

Phone: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Name: _____

Medical Insurance Information

Primary Insurance:_____ Subscriber ID #: _____

Policy Holder Name: _____ Group #: _____

Policy Holder DOB: _____/_____/_____ Policy Holder SS: _____

Relationship to Policy Holder: _____

Secondary Insurance: _____ Subscriber ID #: _____

Policy Holder Name: _____ Group #: _____

Policy Holder DOB: _____/_____/_____ Policy Holder SS: _____

Relationship to Policy Holder: _____

Tertiary Insurance: _____ Subscriber ID #: _____

Policy Holder Name: _____ Group #: _____

Policy Holder DOB: _____/_____/_____ Policy Holder SS: _____

Relationship to Policy Holder: _____

Who referred you to our office ?: _____ **(**Internal Use: *Updated in eClinical)*

OB/GYN: _____ _____

PCP: _____ _____

Other Physicians you see:

_____

_____

_____

_____

_____

Barry J Roseman, M.D

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Name: _____

DOB:_____ Age:_____

Please *briefly* describe the reason for your visit today with Dr. Roseman:

_____

When was your last breast imaging? : _____ **Where was it done?** : _____

Pharmacy Name & Phone Number: _____

List Current Medications: (Include Medications, Vitamins, Herbs, and Supplements)

Name of Med	Dose	How Often	Reason for Taking

Drug, Environmental Allergies

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: : _____ Reaction: _____

Latex Sensitive: YES NO Unkown

Name: _____

Family History of Cancer?

Close Relatives with Breast Cancer? Y / N

Mother? If yes, what age of diagnosis? _____

Sister ? If yes, what age of diagnosis? _____

Other Relatives with Breast Cancer?

Maternal Aunt ____ Paternal Aunt ____ Maternal GM _____ Paternal GM _____ Cousin(s) _____

age of diagnosis? _____

Mother with Ovarian Cancer? ***Y / N*** *If yes, what age of diagnosis? _____*

Sister with Breast Cancer? Y / N *If yes, what age of diagnosis? _____*

Sister with Ovarian Cancer? ***Y / N*** *If yes, what age of diagnosis? _____*

Other History of Cancer: Father Mother Brother Sister Other _____

High Blood Pressure/Heart Problems: Father Mother Brother Sister Other _____

Diabetes: Father Mother Brother Sister Other _____

Social History

Daily Caffeine intake: (coffee, tea, soda, chocolate, and energy drinks): _____

Currently Smoke: Y/ N

How much do you smoke? _____ If so, for how long? _____

Have you ever smoked in the past? Y / N

If so, how much did you smoke and when did you quit? _____

Other forms of Tobacco: Y / N

Alcohol Consumption: Y / N

Frequency: _____Amount per setting: _____ Type: _____

(1 drink = 12oz beer, 4oz wine, 1.5oz liquor)

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Name: _____

Past Medical History

Have you ever had any of the following medical problems in the past?

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding or Hemophilia	☐	☐	Diabetes - Insulin Dependent	☐	☐	Lung Disease
☐	☐	AIDS/ HIV Positive	☐	☐	Diabetes - Oral Medication	☐	☐	Mitral valve prolapse
☐	☐	Alcohol or Drug Abuse	☐	☐	Difficulty Breathing/Shortness of Breath	☐	☐	Osteoporosis or Osteopenia
☐	☐	Allergies or Hay Fever	☐	☐	Emphysema	☐	☐	Pace Maker
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Prosthetic Joint Replacement
☐	☐	Angina Pectoris	☐	☐	Fever Blisters	☐	☐	Psychiatric Problems/Nervous Disorder
☐	☐	Anorexia or Bulimia	☐	☐	Frequent Headaches	☐	☐	Rheumatic fever
☐	☐	Arthritis	☐	☐	Heart Ailments/ Heart Murmur	☐	☐	Sickle Cell Anemia
☐	☐	Artificial Heart Valve	☐	☐	Heart Surgery	☐	☐	Stomach/Gastrointestinal Disorders
☐	☐	Asthma	☐	☐	Hepatitis, liver disease (A/B/C)	☐	☐	Stroke
☐	☐	Bacterial Endocarditis	☐	☐	High blood pressure	☐	☐	Thyroid or Parathyroid disease
☐	☐	Blood Disorders	☐	☐	Kidney Problems/Disease/Dialysis	☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Latex Allergy	☐	☐	Cosmetic Surgery
☐	☐	Colitis	☐	☐	Cosmetic Surgery	☐	☐	Venereal disease
☐	☐	Congenital Heart Defect	☐	☐		☐	☐	Excess Tanning or Use of Tanning Bed

Y	N	
☐	☐	**History of Cancer**
☐	☐	**Chemotherapy**
☐	☐	**Radiation treatment**

Type of Cancer Treated _____

MD who treated you _____

Hospitalizations:

_____

_____

Major Surgery:

_____

_____

_____

Name: _____

Review of Systems (ROS):

Female History:

_____ *Premenopausal*
_____ *Perimenopausal*
_____ *Post-Menopausal*

_____ *Hysterectomy*
_____ *Ovaries Removed*

Have You Ever Been Pregnant? Y / N

Number of Pregnancies _____
Age of Oldest Child _____

Last Mammogram _____
Prior Abnormal Mam? Y / N
Prior Breast Biopsy? Y / N

Breast Augmentation? Y / N
Breast Reduction? Y / N

Current Breast Problems:

_____ *Breast lump / mass*
_____ *Breast pain / tenderness*
_____ *Abnormal Mammogram or US*
_____ *Change of Skin Appearance*
_____ Irregular periods / bleeding
_____ Heavy periods
____ Birth control usage
____ Difficulty with conception
____ History of Abnormal pap results

Current Skin Problems:

_____ *Current Diagnosis of Skin Cancer*
_____ *Current Diagnosis of Melanoma*
_____ *Concern about a Skin Lesion*
_____ *Current use of Tanning Bed*

Circle any that Apply to You

DERMATOLOGY
rash / change in color of moles / dry or sensitive skin / hives

ALLERGY
scratchy throat / itchy eyes / sinus congestion

HEMATOLOGY / LYMPH
easy bruising / frequent nose bleeds/ excessive bleeding / swollen glands / edema

UROLOGY
difficulty urinating / frequent urination / urinary incontinence

SKIN
dry or sensitive skin/ hives / rash / redness / yeast / acne / skin lesions

CONSTITUTIONAL
weight gain / fever / weakness / weight loss / fatigue

ENDOCRINOLOGY
cold intolerance / heat intolerence/ excessive urination / excessive thirst

NEUROLOGY
headache / seizures / syncope/ stroke / memory loss / tingling and/or numbness
vertigo

OPTHALMOLOGY
Cataracts / Glaucoma / intraocular hypertension

RESPIRATORY
shortness of breath / Pain with inspiration/ Persistent cough

ENT
cough / sore throat / nasal congestion/ cough / sore throat / nasal congestion

CARDIOLOGY
chest pain or pressure / shortness of breath / pacemaker / Calf or leg pain
palpitations

GASTROENTEROLOGY
blood in stool / early satiety nausea / heartburn / indigestion/ acid reflux / nausea

MUSCULOSKELETAL
joint pain / leg cramps / arthritis / back trouble / bone pain

PSYCHOLOGY
suicidal ideation / mental or physical abuse/ high stress level / depression /
sleep disturbances

Name: _____ DOB: _____

Financial Policy

Welcome to our office! We are pleased that you have chosen us to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office.

We accept cash, personal checks, American Express, Visa, MasterCard, and Discover for payment on your account. If you have insurance which we do not contract with, you will be expected to make a full or partial payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay any deductible, coinsurance, or copay at the time of your visit.

COMMERCIAL/PRIVATE INSURANCE: As a courtesy, we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. If you owe on your deductible or owe a copay/coinsurance, we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to Surgical Oncology of North Georgia. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

CONTRACTED INSURANCE: We are happy to submit a claim directly to the insurance carrier; as long as the necessary billing information as been provided. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You are still responsible for payment of your deductible, coinsurance, and/or copay at the time of service and any amounts not covered by your insurance. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

_____ **In the event that our physicians are not contracted with your health plan, you will be responsible for any**
Initial here **out of network, coinsurance, or deductible applied.**

NO INSURANCE: If you do not have insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about financial arrangements.

MEDICARE: We are participating providers with Medicare. We will submit your claim to Medicare, and Medicare will process the payments to Surgical Oncology of North Georgia. You are responsible for your deductible and any coinsurance/copay at the time of service.

RETURNED CHECKS: In the event your bank returns your check to our office unpaid, there will be a $35.00 return check fee charged to your account.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred, but also any costs involved in collection of your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collection costs. A collection company may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before you visit. Thank you!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Surgical Oncology of North Georgia and have provided to the best of my ability the information requested accurately and completely.

_____ _____

Patient/Responsible Party Signature Date

Patient Authorization for Use and Disclosure of Protected Health Information

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service.

The provision of this information is optional.

Patient Information:

Last Name	*First Name*	*Middle Initial*	*Date of Birth (MM/DD/YYYY)*
Street Address			*Medical Record #/Social Security # (optional)*
City	*State*	*Zip*	*Primary Contact Number*

If we cannot reach you at the telephone number listed above, Surgical Oncology of North Georgia may contact you (including leaving messages) regarding your appointments, account balance or normal lab results at the followingnumber(s).

Business Number	*Cell Phone Number*	*Other Phone Number*

I authorize Surgical Oncology of North Georgia to disclose Protected Health Information to the following person(s):

Spouse:		
	Name	*Phone Number*
Child(ren):		
	Name	*Phone Number*
	Name	*Phone Number*
Other:		
	Name	*Phone Number*

Information to be disclosed:

All Financial Information ☐ Medical Records ☐ Mammography Images ☐

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing and present my revocation to Surgical Oncology of North Georgia. I understand that the revocation will not apply to information that has already been used or disclosed in response to this Authorization. I understand that Surgical Oncology of North Georgia cannot require me to sign this Authorization as a condition of treatment unless the provision of health care by Surgical Oncology of North Georgia is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I also consent to the use of my anonoymyzed medical information and radiology studies for training and research purposes by Dr. Roseman and an additional third party.*

Signature/Date: (date authorization signed by patient or Legal Guardian/Personal Representative)

Month/Day/Year

Print Patient Name (or Name of Legal Guardian/ Representative)

Signature of Patient or Legal Guardian/ Representative

Indicate relationship to patient (required) _____

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*