RSA Riverside Surgical Associates

Breast Surgery Patients

Today's Date: ____/____/____

Patient's Name: _____ Date of Birth: ____/_____/_____
Primary Care Physician:_____ Referring Physician:_____
Patient's Age:_____ Patient's Occupation:_____
Reason for today's visit:_____

Have you ever had any of the following medical problems? (Please check all that apply.)

☐ Anemia	☐ Cancer	☐ Heart Attack
☐ High Blood Pressure	☐ Stroke	☐ Asthma
☐ Emphysema	☐ Pneumonia	☐ Diabetes
☐ Stomach Ulcers	☐ Colitis	☐ Hernias
☐ Thyroid problems	☐ Jaundice	☐ Back pain
☐ Arthritis	☐ Seizures	☐ Kidney Disease
☐ MRSA Infection	☐ Blood Clots	☐ Other
☐ Change in Bowels	☐ Fractures	

☐ Cancer, what kind _____

Have you ever had surgery? (Please check all that apply.) ☐ No Surgery

☐ Hernia repair	☐ Stomach	☐ Gallbladder	☐ Hemorrhoids
☐ Breast Surgery	☐ Appendectomy	☐ Heart	☐ Colon Surgery

☐ Hysterectomy, Reason for Hysterectomy _____
☐ Cancer Surgery, what kind_____

Medications taken on a daily basis: **PLEASE PRINT CLEARLY**

Medication Name	Dose	Reason for Medication	See Medication List _____
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Do you take any blood thinners (i.e. aspirin, Lovenox, Coumadin, Plavix, Xarelto, Eliquis) ☐Yes ☐No
Do You Smoke? Yes No How Much?_____ When did you quit?_____
Do You Drink? Yes No How Much? _____
Do You Do Drugs? Yes No What Kind?_____

Has any blood relative had: **PLEASE SPECIFY FATHER'S SIDE OR MOTHER'S SIDE**

	Relationship		Relationship
Heart Disease ☐Yes ☐No	_____	Thyroid Problems ☐Yes ☐No	_____
Breast Disease ☐Yes ☐No	_____	Cancer ☐Yes ☐No	_____

OB/GYN History
Age at first period ____ Date of last period_____ Age when first child delivered _____
Number of pregnancies _____ Number of children _____
Do you take, or have you ever taken: Birth control pills_____ Hormonal Replacement Therapy_____

Are you allergic to any <u>medications</u>? ☐Yes ☐No

Penicillin	☐Yes ☐No	Latex	☐Yes ☐No	Sulfa Drugs	☐Yes ☐No
Iodine	☐Yes ☐No	Shellfish	☐Yes ☐No	Other	_____

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Have you been experiencing any of the following:

GEN: ☐ Fever ☐ Chills ☐ Abnormal/unintentional weight loss

HEENT: ☐ Headaches ☐ Dizziness ☐ Syncope ☐Changes in vision

SKIN: ☐ New skin rashes or lesions

HEME: ☐Blood clots ☐Bleeding Disorders ☐Recurrent Infections

CARD: ☐Palpitations ☐Difficulty breathing on exertion ☐Chest pain

☐Inability to walk 2 flights of stairs without chest pain

RESP: ☐Difficulty breathing ☐Wheezing ☐Cough

GASTR: ☐Abdominal Pain ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

GENITO: ☐Abnormal vaginal bleeding or discharge ☐Burning with Urination ☐Blood in urine

MUSC: ☐Bone or joint pain

NEURO: ☐Headache ☐Dizziness ☐Weakness or Numbness

PSYCH: ☐Anxiety or Depression

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Patient Registration Form

Patient Information

Patient Last Name_____ First Name_____ DOB_____/_____/_____

Address_____City_____ State_____ Zip _____

Home Phone:_____ Cell:_____ I prefer to be reached by ☐Cell ☐Home

Email address: _____

☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced

Emergency Contact _____Phone #_____

Preferred Pharmacy _____ Address_____

Is this is a work-related injury? ☐ Yes ☐ No

Primary Insurance

Insurance Name _____ Insurance ID# _____

Insurance Group # _____ Insurance Tel #_____

Person responsible for account (if not the patient):

Last Name_____ First Name_____

DOB_____/_____/_____ Relation to patient _____

Address (if different) _____City_____State_____ Zip_____

Secondary Insurance

Insurance Name _____ Insurance ID# _____

Insurance Group # _____ Insurance Tel #_____

Person responsible for account (if not the patient):

Last Name_____ First Name_____

DOB_____/_____/_____ Relation to patient _____

Address (if different) _____City_____State_____ Zip_____

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CONSENT TO TREATMENT

I am presenting myself for examination and treatment at Riverside Surgical Associates and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the office, and by its medical staff, as may, in their professional judgment, be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.
I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination.

Date	Print Patient's Name	Signature of Patient or Responsible Person	Relationship to Patient

FINANCIAL CONSENTS

Release of Information, Assignment of Benefits, Payment Guarantee

AUTHORIZATION TO RELEASE INFORMATION: Riverside Surgical Associates (RSA) is authorized to release to any insurance companies having coverage on me any information pertaining to the diagnosis and/or procedures relative to this treatment. A photostatic copy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY: In consideration of services rendered, I hereby forever assign and give to RSA all rights, title and interest in the benefits payable for services rendered by RSA, provided by my policy(ies) of insurance. This transaction shall be for the recovery on said policy(ies) of insurance, it shall not be construed to be an obligation of RSA to pursue any such right of recovery. Provided however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company(ies) to pay directly to RSA all benefits due under said policy(ies) by reason of services rendered therein. I will pay RSA for all charges in excess of the sums actually paid pursuant to said policy(ies). A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date	Patient or Parent if Minor	Insured Person

MEDICARE CERTIFICATION

Patient's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Riverside Surgical Association to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Riverside Surgical Associates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I understand that I am responsible for any health insurance deductibles and coinsurance.

Date	Patient's Signature

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Acknowledgement of Receipt of Notice of Privacy Practices

This form accompanies the HIPAA Omnibus Notice of Privacy Practices from Riverside Surgical Associates. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Date

Signature*

Print or Type Name

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature

Relationship

Date