TEMPLETON BREAST CARE
INITIAL VISIT QUESTIONNAIRE

Name:________________ **Date:**_______________

MEDICATIONS: **NONE**

Name	Dose	How Frequently

PAST MEDICAL HISTORY: (Check all that apply)

Yes	No		Yes	No		Yes	No	
		High Blood Pressure			Diabetes			Cancer Type:
		High Cholesterol			Kidney Disease			Thyroid Disease: High Low
		Heart Attack			Hepatitis/Liver Disease			Arthritis
		Angina or Chest Pain			Asthma/COPD			Osteoporosis
		Irregular Rhythm			TB			Depression
		Heart Failure			Blood Clots (DVT or PE)			Other Psychiatric Problems
		Heart Valve Disease			Other Blood Diseases			Alzheimer's disease
		Peripheral Vascular Disease			History of Blood Transfusion			HIV/AIDS
		Stroke			Inflammatory Bowel Disease			Anesthesia problems
		Seizures			Peptic Ulcer/Gastritis			Connective Tissue Diseases
		History of Radiation Treatment			Sleep Apnea			

Other Medical Problems Not listed above:

Details:

ALLERGIES: **NONE**

Drug	What Happened?

TEMPLETON BREAST CARE
INITIAL VISIT QUESTIONNAIRE

Name:_________________ **Date:**_______________

_____________________________ ____

PREVIOUS SURGICAL PROCEDURES (including specifically any *breast procedures*) **NONE**

Date: Procedures:

_______________ ____

_______________ ____

_______________ ____

_______________ ____

_______________ ____

PREVIOUS HOSPITALIZATIONS: **NONE**

Date: Reason for Hospitalization:

_______________ ____

_______________ ____

_______________ ____

_______________ ____

_______________ ____

FAMILY HISTORY: Please indicate if you have a family history of cancer

Family member with cancer	**Status-**Circle one	**Total number of family members with and without cancer**	**Age at cancer diagnosis**	**Site of Cancer**
Mother	Living Deceased			
Sister	Living Deceased			
Daughter	Living Deceased			
Maternal Grandmother	Living Deceased			
Maternal Grandfather	Living Deceased			
Maternal Aunt	Living Deceased			
Maternal Uncle	Living Deceased			
Maternal First Cousin	Living Deceased			
Father	Living Deceased			
Brother	Living Deceased			
Son	Living Deceased			
Paternal Grandmother	Living Deceased			
Paternal Grandfather	Living Deceased			
Paternal Aunt	Living Deceased			
Paternal Uncle	Living Deceased			
Paternal First Cousin	Living Deceased			

Do you have any of the following heritages:

Ashkenazi Jewish	YES	NO
Dutch	YES	NO
Iceland	YES	NO

TEMPLETON BREAST CARE
INITIAL VISIT QUESTIONNAIRE

Name:________________ **Date:______________**

SOCIAL HISTORY:

Religion:______________________________ I will accept blood products: YES NO

Do you drink alcohol: YES NO How much?______________________________

SMOKING: (Circle one)

Current smoker Former smoker Never smoker Current every day smoker Current some day smoker

Occupation:____

BREAST HISTORY:

Date (or age) of your last menstrual period:________________ Are your menstrual cycles regular? YES NO

Have you used hormone replacement?: YES NO If so, for how long:_____________________

If you did in the past, when did you stop:__________________ What medications did you use? __________

____

Have you used pills or hormone shots for contraception?: YES NO

If so, for how long (or approximate dates):____

Have you used pills or hormone shots for infertility? YES NO

If so, for how long (or approximate dates):____

Number of pregnancies: ___________ Deliveries:______________ Miscarriages:______________

Did you nurse? YES NO If so, for how long?____________

What cup size bra do you wear?____________________________

GAIL RISK MODEL:

Age that you had your first menstrual period:________________ Age at time of first delivery:___________

Number of your first-degree relatives –mother, sisters, daughters- have had breast cancer:______________

Have you ever had a breast biopsy? YES NO How many?_______________________

Have any of the biopsies had atypical hyperplasia or abnormal cells? YES NO UNKNOWN

What is your Race/ethnicity? __________________________________

Sandra F. Templeton, M.D.

Specializing in Diseases of the Breast
16605 Southwest Freeway Suite 220
Sugar Land TX, 77479
281-494-3000

In order to maintain patient confidentiality, please indicate below with whom our office can or cannot leave a message.

Please circle one where appropriate:

Spouse: Y N if so,
Name____

Significant Other Y N if so,
Name____

Children Y N if so,
Name____

Relatives: Y N if so,
Name____

Answering Machine?
Y N

May we leave a detailed message?
Y N

May we leave a call back number?
Y N

Are you able to receive calls at work?
Y N

May we leave a message at your job?
Y N

Please be advised that should a relative or friend contact our office, we are not at liberty to discuss your situation.

Patient Name:_____________________________________

Patient Signature:__________________________________ Date:_________________________

Name:____________________ Date:___________________ Year: 2014_

PLEASE ANSWER EACH QUESTION:

PCP NAME:__________________ _____

OB/GYN NAME:_________________________

Constitutional Symptoms:

Y N Fever
Y N Weight Loss
Y N Fatigue

Ear/Nose/Mouth/Throat

Y N Hearing Loss
Y N Dizziness
Y N Voice changes
Y N Sore throat

Musculoskeletal

Y N Joint Pains
Y N Back Pain
Y N Pain in bones
Y N Numbness or Tingling in fingers
Y N Swelling in Upper extremity

Gastrointestinal

Y N Loss of Appetite
Y N Change in Bowel Movements
Y N Frequent Diarrhea
Y N Constipation
Y N Blood in Stool
Y N Abdominal Pain

Eyes

Y N Blurry Vision
Y N Double Vision
Y N Glaucoma

Psychiatric

Y N Depression
Y N Insomnia
Y N Memory Loss
Y N Irritability

Respiratory

Y N Chronic Cough
Y N Asthma
Y N Shortness of Breath
Y N Coughing up Blood

Endocrine

Y N Diabetes
Y N Thyroid Disease
Y N Hot Flashes
Y N Night Sweats

Cardiovascular

Y N Heart Attack
Y N Chest Pain
Y N Palpitations or Arrhythmia
Y N Congestive Heart Failure
Y N Swelling of Ankles or Hands
Y N Hear Murmur
Y N Mitral Valve Prolapse

Hematologic/Lymphatic

Y N Easy Bruising
Y N Anemia
Y N Past Transfusions
Y N Lymphedema
Y N Varicose Veins
Y N History of DVT or Clotting Problems

Neurological

Y N Numbness or Tingling
Y N Seizures
Y N Stroke
Y N Severe Headaches

Skin

Y N Itching or Rash
Y N Change in Skin Color
Y N New Breast Lump
Y N New Nipple Discharge
Y N Scleroderma or Cold Extremities

Genitourinary

Y N Urinary Incontinence
Y N Painful Sexual Intercourse
Y N Irregular Vaginal Bleeding

Signature: ____________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BEUSED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

•

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

•

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

•

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

***NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability &Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and healthcare operations.

I hereby acknowledge that I have been presented with a copy of the Templeton Breast Care's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

PATIENT NAME:______________________________________

SIGNATURE:____

DATE:____

OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgement of this **Notice of Privacy Practice Acknowledgement,** but was unable to do so as documented below:

Date: ____

Initials:____

Reason:____

Templeton Breast Care Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. In order to keep our fees to minimum we require that you pay at the time of service so that we do not have to send bills. We may order laboratory tests, perform office procedures or diagnostic tests as part of our comprehensive evaluation. Payments for these services are due and payable at the time of service. In order to achieve the clinic goals of providing the finest care at the lowest cost, we need your assistance and understanding of our payment policy.

Self-Pay
Full Payment for Professional services due at the time of service. We accept cash, checks, debit/ATM cards, Visa, MasterCard, Discover, and American Express.

Insurance
Payment of Co-Pays and Deductibles are due at the time of service. Service may be denied if payment is not made at check-in time. Our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. By law your insurance company must remit payment or deny your insurance claim within 30 days of initial notice. If your insurance company has not paid your account in full within 45 days we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you. We will file claims to your insurance company but your insurance policy is a contract between you and your insurance company. We are not a party to that contract and so your balance will be due immediately.

Insurance Coverage Changes
In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment of all fees at the time service is rendered. We will file insurance claims immediately for all these services, if requested, and reimbursement from the insurance carrier should be made directly to you. Again, if payments received by the office, a check will be issued to you within 30 days for reimbursement. We ask that you participate in any disputes with your insurance carrier regarding your policy guidelines and insurance payments. If you obtain insurance, including Medicaid, we will bill you carrier beginning when you present us with your new insurance card.

Financial Responsibility for Minors
Unless prior arrangements have been made, charges for minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Returned Checks
Returned checks are subject to a $30 charge, returned checks older than 30 days may be subject to an additional $50 charge. Returned checks may be referred to the District Attorney for legal action in some cases.
As we stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community. Since our practice also has financial obligations which must be met, we ask that all patients pay for their examination and treatment in full on the day of each visit to our office. In regards to insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment.

I have read, understand and agree to abide by the financial policy set forth.

__________________________________ ____________________
Signature of Patient/Responsible Party Date

__________________________________ ____________________
Witness Signature Date

Patient Registration

Patient Last Name:____________________M,I_______

First:___________________________ **DOB**__________

Address:____

Apt #:_______ City, State & Zip:_____________________

Phones: Home:____________________________________

Cell:____

Work__________________________ Ext______________

***Patient Email Address:**__________________________

Responsible Party: (For Patients under 18 yrs)

Name of Person:___________________________________

Relationship to patient:_____________________________

Responsible Party Social Security #:__________________

Primary Insurance Company:

Insurance Name:_____________________________

Policy Holder Name:_______________________________

Policy Holder Date of Birth:_________________________

Relationship to Patient:____________________________

Employer:____

Policy Number:_____________________________________

Group Number:____________________________________

Secondary Insurance Company:

Insurance Name:_________________________________

Policy Holder Name:_______________________________

Policy Holder Date of Birth:_________________________

Relationship to Patient:____________________________

Employer:____

Policy Number:_____________________________________

Group Number:____________________________________

Male Female **Marital Status**: M S D W

Race:____________________ **Ethnicity**:______________

Primary Language:_______________________________

Patient Social Security:____________________________

Patient Employer:__________________________________

Work Status: Full time. Part time, Not employed, Self employed, Retired, Military Duty, Student

Student Status: Full time, Part time, Not a student

____

Who is your Primary Care Doctor?____________________

Who referred you to our office?_______________________

Who is your Ob-Gyn?______________________________

EMERGENCY CONTACT:__________________________

Relationship:_________________________________

PHONE #:_______________________________________

Would you like information on a living will? YES NO

Do you have a living will? YES NO

***Pharmacy Name** :______________________________

Address or Cross streets:________________________

Telephone #:___________________________________

FAX #:____

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Templeton Breast Care. I authorize release of medical information necessary to process this (these) claim (s).I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature:_______________________________________

Date:____

Sandra F. Templeton, M.D.
16605 Southwest Freeway, Suite 220
Sugar Land, TX 77479
Office: 281-494-3000 Fax: 281-494-3010

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I, (PRINTED NAME) ____ AUTHORIZE:

Name of Physician: ____

Address: ____

____

____

Phone: ___________________________ Fax: ________________________________

To provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time, I am requesting the following:

_______ Complete record
_______ Records of care from ______________ to _______________ only
_______ Records of care concerning the following condition(s) ________________
____
____
_______ Other (Please specify) ____
_______ Confer with other person __________________________ orally or written about information in my medical record.

_______ I CONSENT TO THE RELEASE OF ALL HIV/AIDS TEST RESULTS

RELEASE TO: Sandra F. Templeton, M.D.
16605 Southwest Freeway, Suite 220
Sugar Land, TX 77479

SIGNED: ______________________________________ DATE: _____________________