PATIENT REGISTRATION FORM

Dr. Alison Laidley M.D

Dr. Rachel Warren M.D

Name______________________________**Age**________**Referred By**____________________________

Reason/Diagnosis you came for evaluation:____________________________________

O YES O NO Lumps in breast now? If yes, please diagram their location below.

PRESENT ILLNESS

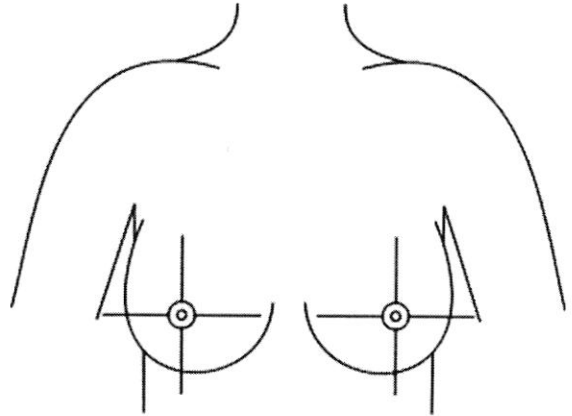
Have you had imaging on the area of concern? YES / NO

Nipple Discharge? Right____ Left_____

Discomfort or soreness: Right____ Left_____

Injury to Breast: Right____ Left_____

When & How:____________________________________



Previous Breast Surgery? Right____ Left_____

Aspiration with Needle? Right____ Left _____

Biopsy? Right____ Left _____

Other? Right____ Left _____

Mastectomy? Right _____ Left _____

Breast Implants? Right _____ Left _____

Lumpectomy for cancer? Right _____ Left _____

Do you use any of the following? (Please check all that apply)

Alcohol O Yes O No How Often: Rare Occasional Heavy

Smoking O Yes O No Type:____________________

Caffeine O Yes O No How Often: ___________ Type:______________

Reproductive History:

Number of Pregnancies:_________ Number of children:___________ Age at first Birth:_________________

Did you breast feed? Yes No If yes, for how long (Approximate)____________ # of children breast fed?_____

Age at first Period:__________ Age of Menopause: ____________ Last Menstrual Period:____________________

Hysterectomy: Yes No Hormone use: Yes No

Preventative Health Maintenance:

Last Pap Smear:_______________ Last Colonoscopy:______________

Last Flu Vaccine:_______________ Last Pneumonia Vaccine:______________

*Advanced Directives: **O** Yes **O** No if yes for any, please check all that apply:*

____Living Will ____Medical Power of Attorney ____DNR(Office-Out of Hospital)

PERSONAL AND FAMILY MEDICAL HISTORY:

Family History of Breast Cancer:

Is there any family history of Breast Cancer? **O** Yes **O** No

O Self **O** Grandmother **O** Mother **O** Sister **O** Aunt **O** Daughter **O** Other

Is there any family history of ANY cancer?

O Yes **O** No Yes? Who and what type: ______________________________

Medical History:

Are you allergic to any medications? ____

Any skin allergies/sensitivities (tape, adhesive, etc.)? ______________________________________

Additional Medical Condition History

Diagnosis/Condition	Physician Name

If you are currently taking any prescription medications, please list below OR attach updated medication list.

Medication and Dosage	Medication and Dosage
1.	2.
3.	4.
5.	6.
7.	8.

SURGERY HISTORY

Surgery/Injury/Hospitalization	Date Occurred

Patient Name:______________________________ **Date of Birth:** ____________________

Review of Systems- check symptoms you currently have or had in the past year:

Breast:
__Breast Cancer R / L
__Breast mass R / L
__Breast pain R / L
__Breast swelling R / L
__Nipple Discharge R / L
__Nipple Pain R / L

General:
__Chills
__ Fatigue
__Fever
__Night Sweats
__Weight Gain or loss (10lbs)

Skin:
__Bruising
__Rash
__Skin Color Changes

HEENT:
__Blurred vision
__Chronic Cough
__Tuberculosis

Cardiovascular:
__Chest pain
__Difficulty Breathing
__Irregular Heart Beat
__Elevated Blood Pressure
__Pacemaker

Musculoskeletal:
__Muscle Pain
__Bone Pain
__Lymphedema

Psychiatric:
__Anxiety
__Depression
__Insomnia
__Panic Attacks

Endocrine:
__Cold/Hot Intolerance
__Hair Changes
__Libido Changes
__Thyroid Problems

Hematology:
__Abnormal bleeding
__Enlarged lymph nodes
__Nose Bleed
__Anemia
__HIV or AIDS

Gastrointestinal:
__Abdominal Pain
__Change in bowel habits
__Nausea & Vomiting
__Hepatitis A, B, or C

Female Genitourinary:
__Are you currently pregnant
__Are you currently breastfeeding
__Complications with menstrual cycle

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made on this form.

Patient Signature: ____________________________ Today's Date: __________________

Texas Breast Specialists

7777 Forest Lane, C-614
Dallas, TX 75230
Phone: 972-566-7499 Fax: 972-566-6428

Medical Information Release Form

(HIPAA Release Form)

Name:_________________________________ Date of Birth:______/______/______

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ___________________________
[ ] Child(ren) ___________________________
[ ] Other ___________________________

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my: [ ] Home [ ] Work [ ] Cell #______________________

If unable to reach me:

[ ] you *may* leave a detailed message
[ ] please leave a message asking me to return your call
[ ] you *may not* leave a message

Signature: ___________________________ Date: ______/______/______

Witness: ___________________________ Date: ______/______/______

TEXAS BREAST SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Breast Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Breast Specialists.

Name: ______________________________

Signature: ______________________________

Name of Personal Representative (if appropriate): ____________________________________

Signature of Personal Representative (if appropriate): __________________________________

Date _______________________

Texas Breast Specialists Use Only

Date acknowledgement received: __________________________________

-OR-

Reason acknowledgement was **NOT** obtained:

____

____

____

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit manager may be viewable by designated providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive, and/or access my prescription history.

I understand that this prescription History Consent will be valid and remain in effect as long as I attend or continue to receive services from Texas Oncology, unless revoked by me in writing. Such written notice will be provided to each practice site I attend or from which I received services.

I certify that I have read this form or it has been read to me.

Print Name (patient): ______________________________ **DOB:** ____________________

Date: ______________________

Signature of patient/legally authorized representative

____

Relationship to patient (If patient not signing): ____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader / Translator Signature: _________________________ Date: __________________

User Electronic Mail Authorization Form

Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health records as the patient, you are in control of your Portal record: We will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute the User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to crease a password to access the Portal. Please look for an email from **"My Care Plus"** promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact you physician's office to provide your new email contact information so that you will continue to receive updated and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

TERMS

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. **Please write Legibly**

____

Patient Name
(First Name, Middle Initial, Last Name)

____

Email Address of Patient/Authorized User

____

Date of Birth of Patient

Alison L. Laidley/ Rachel Warren

Physician's Name

Authorized User is:

○ Patient

○ Patient's Designee

____

Patient's Designee's Name (Printed)

____

Patient's Designee's Signature

____

Patient's Signature

____

Date

____

Signature of practice staff
[confirming user's identity and authority]

____

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person understands and agrees to use the listed email address for this purpose. Please make copy for patient.

Staff use only:	MRN__________
Email in PMS of iKM______	iKM Consent__________

Texas Breast S

Alison Laidley, M.D.
Rachel Warren M.D.
7777 Forest Lane C-614
Dallas, TX 75230
P) 972-566-7499
F) 972-566-6428

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I give authorization for…

(Please check the appropriate box)

☐ Pathology Department ☐ Dr.______________

…to disclose my medical records to: **Texas Breast Specialists Medical City Dallas**

Address: 7777 Forest Lane C-614 Dallas, TX 75230 Phone: 972-566-7499 Fax: 972-566-6428

These records will include the following information as indicated:

___Mammogram & Sonogram Reports ___MD Progress Notes

___Pathology Reports ___Other:___________________________

For the purpose of:

Changing Doctors due to:

____ Insurance Change/Network Provider ____ Second Opinion ____ Moving

____ Continuation of Care ____Other: ___________________________

The patient has the right to revoke this consent in writing up to the time that records have been sent. This consent is valid for Thirty (30) days from the date of signature. I understand that there may be a fee for preparing this information.

I hereby release Texas Breast Specialists for any/all legal liability that may arise from the release of this information to the party described above.

Patients Printed Name: ____

Complete Address: ______________________________City:___________ Zip Code:_________

Patients DOB: _____/_____/_____

Home Phone: __________________Cell Phone:__________________

Party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without a specific written consent from whom it pertains to, or those permitted by such regulations. Authorization for release of medical or other information is not sufficient for this purpose.

Patient Signature: ______________________________________ Date: __________________

WITNESS: ____