TEXAS BREAST SPECIALISTS

Higher Standards • Greater Hope

JAMIE E. TERRY, M.D., FACS

GENERAL SURGERY

Patient Information

Date: _____

Patient Name: _____

Phone: _____ Cellular: _____

Age: _____ Date of Birth: _____ Marital Status: S M D W

Address: _____

City/State: _____ Zip: _____

Student: _____ Full time _____ Part Time School Name: _____

Employer: _____ Phone: _____

Address: _____ Occupation: _____

City/State: _____ Zip Code: _____

Spouse or Guarantor's Information

Name: _____ Employer: _____

Employer Address: _____ Phone: _____

City/State: _____ Zip Code: _____

Emergency & PCP Referral Information

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Home Address: _____ City/State: _____

PCP Referred By: _____ Phone: _____

Allergies or Other Conditions: _____

Insurance Information

Primary Insurance: _____ Group Number: _____

Policy Holder: _____ I.D. Number: _____

Mail Claims to: _____ Insurance Phone: _____

Secondary Insurance: _____ Group Number: _____

Policy Holder: _____ I.D. Number: _____

Mail Claims to: _____ Insurance Phone: _____

***** No Secondary Insurance: X** _____ ****

Patient Signature _____ **Date** _____

TEXAS BREAST SPECIALISTS

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NAME: _____

DOB: _____ MRM _____

Please complete the following information concerning your medical history. This information enables Dr. Terry to treat your condition. Thank you for your assistance.

TODAYS'S DATE: _____

FAMILY AND PERSONAL HISTORY

FATHER: ALIVE ___ YES ___ NO

CAUSE OF DEATH: _____

MOTHER: ALIVE ___ YES ___ NO

CAUSE OF DEATH: _____

HOW MANY SISTERS? ___

HOW MANY BROTHERS? ___

WHAT IS THEIR HEALTH STATUS?

_____

_____

WHAT DID YOUR SISTERS AND/OR BROTHERS DIE OF?

_____

_____

CHECK ANY ILLNESS THAT HAVE OCCURRED IN ANY

	FAMILY MEMBERS	YOURSELF
HEART DISEASE	_____	_____
STROKE	_____	_____
HIGH BLOOD	_____	_____
BAD NERVES	_____	_____
TB	_____	_____
ALLERGIES	_____	_____
DIABETES	_____	_____
BLEEDING DISORDER	_____	_____
CANCER	_____	_____
KIDNEY FAILURE	_____	_____
SYPHILIS	_____	_____
GLAUCOMA	_____	_____
CATARACT	_____	_____
ARTHRITIS	_____	_____
ASTHMA	_____	_____
BREATHING PROBLEMS	_____	_____
VEIN PROBLEMS	_____	_____
BLOOD CLOTS	_____	_____
GONORRHEA	_____	_____
HIV/AIDS	_____	_____
RHEUMATIC FEVER	_____	_____

OTHER CONDITIONS:

_____

DATE OF LAST MENSTRUAL: _____

REGULAR ___ IRREGULAR ___

ARE YOU ALLERGIC TO ANY MEDICINE OR SUBSTANCE? ___ NO ___ YES

IF SO PLEASE LIST:

_____

_____

DO YOU USE ANY OF THE FOLLOWING?

SUBSTANCE	HOW MUCH	HOW LONG
TOBACCO	_____	_____
ALCOHOL	_____	_____
COCAINE	_____	_____
MARIJUANA	_____	_____
OTHER:		
_____	_____	_____
_____	_____	_____

IMMUNIZATION HISTORY

SMALL POX _____ TETANUS _____

CHICKENPOX _____ MEASLES _____

POLIO _____ INFLUENZA _____

TYPHOID _____ DIPHTHERIA _____

OTHER _____

PREVIOUS OPERATIONS

OPERATION	DATE	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN:

MEDICATION	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DOCTOR'S NOTES:

_____

JAMIE E. TERRY, M.D.

CONFIDENTIAL AND SENSITIVE INFORMATION

REQUEST FOR SOCIAL SECURITY NUMBER

At Texas Breast Specialists, we are concerned about our patients' privacy and security, particularly as it relates to their Social Security Numbers (SSN). All too frequently, we are all asked for our SSN in situations where that information is not even needed, and most of us provide it without ever questioning the need for it. Yet on an increasing basis, SSNs are being misused for identity theft, and unfortunately, that trend is occurring even in the health care industry.

In an effort to protect our patients, Texas Breast Specialists has made a concerted effort to avoid asking patients for your SSN unless there is a specific, identifiable and unavoidable need for that information. Some situations we have identified where the SSN is necessary, for example enrolling patients in external drug replacement programs or qualifying for financial assistance. While we cannot avoid asking for your SSN in all cases, we promise to ask for it only if it is necessary and, if we must ask for your SSN, to limit access to it and implement other safeguards to protect it from misuse.

The purpose for requesting your SSN includes:

- Required by hospitals to schedule surgery
- Employer Groups where the card states policy number is SSN
- Required by application for external drug replacement program(s)
- Required by application for financial assistance program(s)
- Required by State of Texas Tumor Registry
- Required by State of Texas websites, as needed
- Required by Federal Government PET Registry
- JCAHO – Joint Commission on Accreditation of Healthcare Organizations

"I hereby consent to the use of my Social Security for the above purpose(s)."

_____ _____

Signature Date

_____ _____

Printed Name Patient's Social Security Number

Patient Account Number: _____

TEXAS ONCOLOGY

Due to new Medicare and Insurance billing requirements, all paperwork must have the patient's name exactly as it appears on the Medicare and or Insurance card.

As such, please complete the attached paperwork with your information EXACTLY as it appears on your Medicare and or Insurance card including middle initials, Jr., etc.

Thanks you for your cooperation in this very important matter!

Print Name: _____

Signature: _____

Date: _____

TEXAS ONCOLOGY

PATIENT CONFIDENTIALITY QUESTIONNAIRE

I. Please list the family members or other persons, if any, that we may inform about your general medical condition and your diagnosis:

_____ _____

_____ _____

II. Please list the family members or significant others, if any, that we may inform about medical condition **ONLY IN AN EMERGENCY:**

_____ _____

_____ _____

III. Please print where you would prefer to have your billing statement and/or correspondence from our office sent **if other than your home address.**

Address _____

City _____ State _____ Zip code _____

IV. Please list the telephone number where you would like to receive phone calls Concerning your appointments, lab and x-ray results, or other health information if other than your home phone number. **Please be aware that a cell phone is not a secure and private line.**

Phone number _____

V. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

Yes _____ No _____

VI. Please list the fax number where you would like medical information/records to be Faxed. **PLEASE BE AWARE THAT A FAX NUMBER IS NOT A SECURE AND PRIVATE MEANS OF COMMUNICATION.**

Patient Name (guardian if under 18 years): _____

Patient Signature & Date _____

TEXAS ONCOLOGY

"INDIVIDUALS YOU DO NOT WANT INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE"

Patient Name:_____

Patient Acct. #:_____

Date of Birth: _____

According to our Notice of Privacy Practices, we may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps you pay for your care. If you would like us to refrain from releasing your health information to a family member or friend, please list the name(s) of who you **DO NOT** want your private health information released to on the lines below. Remember, in the future, if there are additions to this list, please notify the Texas Oncology staff. This authorization will remain in effect until revoked by you in writing. Thank you.

_____

_____

_____

_____

Signature: _____ Date: _____

TEXAS ONCOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology 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 Oncology.

Name: (Please Print)_____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Texas Oncology Use Only
Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____

_____

_____

_____

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 record. 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 this 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 create a password in order 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 your physician's office in order to provide your new email contact information so that you will continue to receive updates 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

_____
Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

_____
Patient's Designee's Name (Printed)

_____
Patient's Designee's Signature

_____
Patient's Medical Record Number

_____
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 (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient.

Staff Use Only:	MRN_____
Email in PMS or iKM_____	iKM Consent_____