NEW PATIENT INFORMATION

Date:

Last Name			Primary Care Physician	
First Name	MI		Referring Provider	
Previous Name			Date of Birth (mm/dd/yyyy)	
Address			Gender □ Male □ Female	
City			Marital Status □ Single □ Divorced □ Married □ Widowed	
State	Zip	County	Race : □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific □ Black or African American □ White □ Hispanic □ Other □ Refuse to report	
Home Phone	Cell Phone		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to report	
Work Phone	Ext.		Social Security Number	
Email Address			Emergency Contact Name & Relation	Emergency Contact Ph #
Preferred Pharmacy			Pharmacy Location	Pharmacy Telephone #

Responsible Party or Guarantor (If under 18 years of age)

Last Name		Relation		
First Name	MI	Address		
Home Phone	Cell Phone	City	State	Zip

Patient Employer Information

☐ Employed ☐ Retired ☐ Full-time Student ☐Part-time Student ☐ Disabled ☐ Unemployed

Employer Name		Occupation		
Address	City	State	Zip	Work Phone

Insurance Information

Primary Insurance Company Name	Subscriber’s Name	Subscriber’s Date of Birth
Subscriber’s Social Security/ID Number	Subscriber’s Address	Subscriber’s Home Phone
Secondary Insurance Company Name	Subscriber’s Name	Subscriber’s Date of Birth

Name ______________________________ Age ________ Date ____________________

Complaint ____

Age 1st Menstrual Cycle ________ Date of Last Menstrual Cycle ________________________

Have you ever taken Birth Control? **YES** **NO** # Years Taken ______________ # Years Off _____________

Pregnancies ____________ # Children_____________ Age at 1st Delivery ____________

Have you ever taken hormones or hormone replacement therapy? YES NO

Name ___________________________________ # Years Taken ______________ # Years Off _____________

Do you perform self-breast exams? **YES** **NO**

Have you ever noticed any changes in your breasts (Redness, Dimpling, Discharge, Masses, etc.)? **YES** **NO**

If yes, please explain____

Have you ever had a breast biopsy? **YES** **NO** If Yes **Right** **Left** Date _______________

Type of biopsy _______________________ Results ____

Do you have a family history of any of the following cancers? If yes, list family member, relation to you, and age at diagnosis.

Breast ____

Ovarian ____

Colon ____

Prostate ____

Pancreas ____

Thyroid ____

Uterine ____

Have you ever been diagnosed with cancer? **YES** **NO** When _______________________________

Type ____________________________ Treatments ____

Has anyone in your family had genetic testing? **YES** **NO** Results ____

Ashkenazi Heritage? **YES** **NO**

OFFICE USE ONLY: 10 YEAR _____________% LIFETIME_____________%

TIDELANDS HEALTH
COASTAL CAROLINA
BREAST CENTER

PAST MEDICAL HISTORY

MEDICAL HISTORY	PATIENT	FAMILY	WHO? / EXPLAIN
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	____________________
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	____________________
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Stroke/TIA	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Paralysis	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Phlebitis/DVT/Blood Clots	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Anemia	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Bleeding Problem	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Lung Disease	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Miscarriage	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Heart Trouble	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Defibrillator	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Gout	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Seizures	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Lupus	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Gall Stones	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Pancreatitis	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Hemorrhoids	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Ulcerative Colitis	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Crohns Disease	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Scleroderma	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Thyroid Disease	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Psyciatric Illness	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Blood Transfusion	☐ Yes ☐ No	☐ Yes ☐ No	____________________
Other not listed above	☐ Yes ☐ No	☐ Yes ☐ No	____________________

SURGICAL HISTORY

Hysterectomy Yes No Date: ____________________

Ovaries Removed Yes No Date: _______________

Past Surgical History: Please list any hospitalizations or operations including dates:

____

____

____

____

____

MEDICATIONS/ ALLERGIES

Present Medications: Please list all prescription and over the counter medications taken with the name of the medication, strength and dosage:

Name **Strength** **Dosage**

____
____
____
____
____
____
____
____
____
____
____
____
____

Drug Allergies: Please list names of drug allergies and types of reactions:

____
____
____

SOCIAL HISTORY

Please circle:

Marital Status:	Single	Married	Widowed	Divorced	Separated	
Alcohol Consumption:	Never	Rarely	Moderately	Socially	Frequently	Excessively
Tobacco Use:	Previous	Current	Never	Chewed		
	How much?		How long?		Date quit?	

Do you now or have you ever had a problem with alcoholism or drug addiction? _______________________________________

Daily caffeine Intake (# cups, etc..):____________________________________

Signature of Patient (or patient's personal representative):____

Relationship of representative to patient: _______________________________ Date: _____________

TIDELANDS HEALTH
COASTAL CAROLINA
BREAST CENTER

REVIEW OF SYSTEMS

GENERAL SYMPTONS:

Good general health lately YES____ NO____

Fatigue YES____ NO____

Height __________ Weight__________

EYES:

Blurred or double vision YES____ NO____

Glaucoma YES____ NO____

Wear glasses or contacts YES____ NO____

Cataracts YES____ NO____

EARS/NOSE/MOUTH/THROAT:

Hearing Loss or ringing YES____ NO____

Earaches YES____ NO____

Chronic Sinus Problems YES____ NO____

Nose Bleeds YES____ NO____

Sore Throat/Mouth Sores YES____ NO____

Swollen glands in neck YES____ NO____

GASTROINTESTINAL:

Frequent Heartburn YES____ NO____

Frequent Diarrhea YES____ NO____

Constipation YES____ NO____

Blood in Stool YES____ NO____

INTEGUMENTARY (SKIN):

Heat or cold intolerance YES____ NO____

Rash or itching YES____ NO____

Slow to heal after cuts YES____ NO____

MUSCULOSKELETAL:

Joint pain or stiffness YES____ NO____

Back pain YES____ NO____

Swelling of extremities YES____ NO____

Weakness muscles/joints YES____NO____

osteoarthritis YES____ NO____

CARDIOVASCULAR:

Irregular heartbeat/ Palpitations YES____ NO____

Chest Pain YES____ NO____

RESPIRATORY:

Chronic or frequent coughs YES____ NO____

Spitting up blood YES____ NO____

Shortness of breath YES____ NO____

Asthma or Wheezing YES____ NO____

Emphysema YES____ NO____

Tuberculosis YES____ NO____

Sleep Apnea YES____ NO____

PSYCHIATRIC:

Anxiety YES____ NO____

Memory Loss of confusion YES____NO____

Depression YES____NO____

Claustrophobia YES____ NO____

ENDOCRINE/HEPATIC:

Glandular or hormone YES____ NO____

Thyroid Disease YES____ NO____

Excessive thirst/urination YES____ NO____

HEMATOLOGIC/LYMPHATIC:

Hepatitis YES____ NO____

Bleeding or bruising YES____ NO____

Anemia YES____ NO____

Lymphedema YES____ NO____

HIV/AIDS YES____ NO____

Varicose Veins YES____ NO____

GENITOURINARY:

Frequent urination YES____ NO____

Painful urination YES____ NO____

Blood in urine YES____ NO____

Incontinence/Dribble YES____ NO____

Female-irregular periods YES____ NO____

Kidney Problem YES____ NO____

Dialysis YES____ NO____

Kidney Transplant YES____ NO____

NEUROLOGICAL:

Frequent headache YES____ NO____

Lighthead/Dizziness YES____ NO____

BREAST:

Discoloration YES____ NO____

Pain YES____ NO____

Lump/Mass YES____ NO____

Discharge YES____ NO____

If YES to any above:
Right ___ Left ___

PATIENT REQUEST FOR CONFIDENTAL COMMUNICATION & MEDICAL TREATMENT CONSENT

Patient Name: ____

Patient Date of Birth: ______________________________________ Patient SSN: ________________________

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

_____ Please do not phone me at home. Use the following alternative phone number to contact me:_______________

_____Please do not phone me at work. Use the following alternative number to contact me:______________________

_____ Please do not contact me by email.

_____ Other request(s) (describe in detail): ____

____

_____ When contacting me by phone it is ok to leave messages and discuss my health information with:

Name:___________________________________Relationship_________________

Name: ___________________________________Relationship _________________

________ (Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Data Base be released to TIDELANDS HEALTH GROUP.

ADVANCED DIRECTIVE PLANNING

Do you have an Advanced Directive? □ Living Will □ Power of Attorney □ DNR □ I do not have an Advanced Directive

If you have a Healthcare Power of Attorney (A person you want to make decisions about your health if you are too ill to do so), please provide information below:

Name: ______________________________ Contact Information: __________________________

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by TIDELANDS HEALTH GROUP and its' associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.

ASSIGNMENT OF BENEFITS & PATIENT RESPONSIBILITY

I certify the information on all TIDELANDS HEALTH GROUP forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):____

Relationship of representative to patient: ____________________________ Date: ___________

NOTICE OF PRIVACY PRACTICES-HIPAA

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW PATIENTS CAN OBTAIN ACCESS TO THIS INFORMATION.

We have a legal duty to safeguard our patients protected health information. The Privacy Rights and Practices of **TIDELANDS HEALTH GROUP** established to protect the health information of our patients as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The following categories describe different ways we may use and disclose medical information without your specific consent or authorization. Not all possible uses and disclosures are listed.

- **For Treatment**: We may use and disclose your medical information to provide you with medical treatment and services.
- **For Payment:** We may use and disclose your medical information to bill and collect payments for medical services rendered.
- **Health Care Operations:** We may use and disclose your medical information for health care operations to assure that you receive quality care.

Other Uses or Disclosures that Can Be Made Without Consent or Authorization

- **Public Health Activities**
- **Health Inspection Agencies**
- **Law Enforcement Purposes**
- **Workers Compensation**
- **Government Functions (Military/ Veterans Activities)**
- **Reporting Abuse, Neglect, or Domestic Violence**
- **Judicial Proceedings**
- **Disclosures about Decedents (Coroner/Funeral Director)**
- **Avert Serious Threat to Public Health or Safety**

YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION:

- The Right to request limits on uses and disclosures of your health information.
- The Right to choose how we send health information to you or how we contact you.
- The Right to see or to get a copy of your protected health information.
- The Right to receive a list of certain disclosures of your health information that we have made.
- The Right to ask to correct or update your health information.
- The Right to ask questions about the Privacy Policy.
- **The Right to opt out of fundraising communications**
- **The Right to restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full.**
- **The Right to notice in the event of a breach of unsecured PHI**
- **The Right to limit the use of genetic information for health plan underwriting purposes.**
- The Right to file a complaint with **TIDELANDS HEALTH GROUP** or the Secretary of Health and Human Services without the fear of any reprisals if you feel your rights have been violated.

TIDELANDS HEALTH GROUP is required by law to abide by the terms outlined in this notice. However, **TIDELANDS HEALTH GROUP** reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. Before we make an important change to our policies, we will promptly change this Notice and post a new Notice in our receptionist area. You may also request a copy of our Notice of Privacy Practices at any time.

Patient Name: ____ Date____________

Patient/Guardian Signature: ____