Dear_____

Welcome and thank you for choosing New York Breast Health. For many years, our Physicians have been providing premium comprehensive healthcare for our patients in state-of-the-art medical centers using the latest treatment therapies. Always on the cutting edge of technology and medicine, our physicians make certain that our patients are treated with dignity, comfort, and the utmost respect.

You presently have a new patient appointment scheduled with:

Dr._____ **Date**_____ **Time**_____

Location_____ **Phone**_____

We ask that you please arrive 15 minutes prior to your scheduled appointment time for registration. Enclosed are forms for you to complete and bring with you. Kindly also bring any records of your diagnosis, photo ID, and insurance cards. If you have insurance that requires a referral, please obtain it **prior** to your appointment. If your insurance requires a copay, please remember that this is due at the time of your appointment.

Please feel free to contact our **New Patient Navigators** or visit our website, www.nybreasthealth.com, to answer any other questions you might have and to learn more about us.

Thank you for trusting New York Breast Health with your care.

We look forward to seeing you!

PATIENT INFORMATION SHEET

Today's Date _____

First Name:	Middle Initial:	Last Name:
Date of Birth:	Social Security # (opt):	
Street Address:		Apt. #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Work Phone:	Email Address:	
Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Email	Preferred Language:	
Emergency Contact *(First Name & Last Name):*		
Phone Number:	Relationship:	

Sex at Birth: ☐ Male ☐ Female	**Marital Status:** ☐ S ☐ M ☐ D ☐ W	**Occupation:**
Gender Identity:	☐ Identifies as female ☐ Identifies as Male ☐ Identifies as non-conforming ☐ Male to Female transsexual ☐ Female to Male transsexual ☐ Other	
Sexual Orientation:	☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose	

Race:	☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Hispanic ☐ Japanese ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____ ☐ Patient Declined
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Referring Physician *(First Name & Last Name)*:	Referring MD Phone #:
Family Doctor *(First Name & Last Name)*:	Family Doctor Phone #:
OB/GYN *(First Name & Last Name)*:	OB/GYN Phone #:
List Other Physicians *(First Name & Last Name)*:	List Other Physician's Phone #:

Primary Insurance:	ID#:
Subscriber *(First Name & Last Name):*	
Subscriber DOB:	Subscriber Relationship:
Secondary Insurance:	ID#:
Subscriber *(First Name & Last Name):*	
Subscriber DOB:	Subscriber Relationship:

Are you currently a resident in any of the following?:		
In-patient rehabilitation center: ☐Yes ☐No	Skilled Nursing Facility: ☐Yes ☐No	Nursing home: ☐Yes ☐No

Do you have the following Advanced Directives (Check all that apply):				
☐ Durable Power of Attorney	☐ Living Will	☐ Health Care Proxy	☐ DNR	☐ None

*If you **require assistance with Advanced Directive planning**, we are here to help!*
Please ask our team about the 5 Wishes Packet available in-office.

Patient Signature _____ Today's Date _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Address _____
(Street) *(Apt. #)*

_____
(City) *(State/Zip)*

Authorization is Hereby Given to the following doctor(s) to provide New York Breast Health with access to MY MEDICAL AND/OR HOSPITAL RECORDS (fax: _____):

Dr. _____ Phone # _____

Dr. _____ Phone # _____

Dr. _____ Phone # _____

1. Records regarding admission and/or treatment for the following dates of service:

   From: _____ To: _____

2. The following specified information:

   A. Blood work Yes _____ No _____

   B. Radiology Yes _____ No _____

   C. Pathology Yes _____ No _____

   D. All of the above Yes _____ No _____

   E. Specifics _____

   _____

   _____

_____ _____
Patient Signature Today's Date

_____ _____
Witness Name Relation to patient

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

OK to leave a message with detailed information: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
Message with call-back number ONLY: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Written Communication		
OK to mail to my home address	☐ YES	☐ NO
OK to mail to my work/office address	☐ YES	☐ NO
OK to fax records	☐ YES (Fax Number: _____)	☐ NO

Who may we release your medical record information to?

First Name:	Last Name:
Relationship:	Phone Number:

First Name:	Last Name:
Relationship:	Phone Number:

First Name:	Last Name:
Relationship:	Phone Number:

First Name:	Last Name:
Relationship:	Phone Number:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of any requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, If completed properly, will constitute an adequate record. *Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

_____ _____

Patient Signature Today's Date

_____ _____

Print Name Date of Birth

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

By signing this form, you acknowledge that we have provided you with information regarding access to our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. Our ***Notice of Privacy Practices*** can be provided to you upon request or found on the New York Breast Health's website. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgment for the Notice as soon as we can once the emergency has passed.

☐ I have received information on how to access the Notice of Privacy Practices *(effective date February 14, 2018)*.

RESPONSIBILITY AND CONSENT STATEMENT

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other Health Plan to New York Breast Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original.

PLEASE NOTE THAT THE ABOVE NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM AND ATTACHED PATIENT RECORD OF DISCLOSURES FORM MUST BE COMPLETED AS REQUIRED UNDER HIPAA GUIDELINES LAW YOUR SIGNATURE IS REQUIRED FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED

Non-Medicare Patient: I authorize the release of all medical information necessary to process my claims and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to Physician/Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Medicare and Medicaid Patient: I request that authorized Medicare benefits be paid to me or on my behalf to the Physician/Clinic for any services furnished to me by the provider. I authorize any holder of medical information about me to release any information needed to determine benefits or the benefits payable for related services to the Health Care Financing Administration and its agents. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I authorize New York Breast Health to act on my behalf to apply for and release my personal information to all assistance programs which release will be limited to the extent necessary to help me with my financial needs. I agree to provide accurate proof of income upon request by New York Breast Health, or any other foundation or assistance program. Enrollment in a Patient Assistance copay or foundation program does not guarantee that assistance will be obtained. Assistance is subject to approval under the program guidelines. I understand that all Foundation or Copay assistance is subject to availability of funds at the time funds are requested and that this is not a guarantee of payment. I acknowledge and agree that my decision to obtain medical care through New York Breast Health was not based on any promise of financial assistance.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. I HAVE READ THIS INFORMATION AND UNDERSTAND IT. I hereby authorize said assignee to release all information necessary to secure payment. In the event this account is assigned to the collection, I agree to pay all costs of collection, including reasonable attorney fees. Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your coverage with them, not with our office. You are responsible for paying the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

_____ _____

Patient's Signature Today's Date

_____ _____

Subscriber's Signature Today's Date

Healthix

AUTHORIZATION FOR ACCESS TO PATIENT INFORMATION

New York State Department of Health
Through a Health Information Exchange Organization

Patient Identification Number _____ Date of Birth _____

Patient First & Last Name _____

Patient Address _____ City _____ State _____

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow New York Breast Health to access my medical records through the health information exchange organization Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to access my information to decide whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. *ONE box is checked to the left of my choice.*

I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for New York Breast Health to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for New York Breast Health to access my electronic health information through Healthix for any purpose.

**If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.*

My questions about this form have been answered, and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative _____ Date _____

Print Name of Legal Representative (if applicable) _____

Relationship of Legal Representative to Patient (if applicable) _____

BREAST MEDICAL HISTORY

NOTE: This is a confidential record and will be kept at your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE _____

First Name:	Last Name:	DOB:	Age:
Accompanied by (First & Last Name):		Relationship:	

CHIEF COMPLAINT:

What is the reason for today's visit?

PAST MEDICAL HISTORY:

When was your LAST PAP?	Date:	Where:	☐ Never
When was your LAST Mammogram?	Date:	Where:	☐ Never
When was your LAST Sonogram?	Date:	Where:	☐ Never
When was your LAST Breast MRI?	Date:	Where:	☐ Never
When was your LAST Colonoscopy?	Date:	Where:	☐ Never
When was your LAST Bone Density?	Date:	Where:	☐ Never
When was your LAST Skin Check?	Date:	Where:	☐ Never
When was your LAST Flu Shot?	Date:	Where:	☐ Never
When was your LAST Pneumococcal Vaccine?	Date:	Where:	☐ Never
COVID Vaccine Dose 1 *(Brand)*:	Date:	Brand:	☐ Never
COVID Vaccine Dose 2 *(Brand)*:	Date:	Brand:	☐ Never
Booster Brand & Date *(if multiple list all)*:			

Do you conduct **self-breast** exams? ☐ Yes ☐ No	Last exam by a physician? _____	
Age of **first** menstrual period: _____	Date of **last** menstrual period: _____	☐ Now
Age of **first** Pregnancy: _____	Age at the birth of **first** child: _____	
How many:	Live Births: _____ Miscarriages: _____ Terminations: _____ Ectopic: _____	
How many children did you breastfeed? _____	For how long? _____	
Have You Ever Taken Birth Control Pills? ☐ Yes ☐ No	For how long? _____	
Have You Ever Taken Hormone Medication Of Any Type? *(Includes Pills, Creams, and Injections)*: ☐ Yes ☐ No		
Medication Name:	Duration of use:	
Do You Take Soy Supplements Or Vitamins/Herbs Of Any Type? ☐ Yes ☐ No		
If **Yes**, please list and describe:		

LIST AMOUNT CONSUMED:

Coffee: _____ Cups/Day	Tea: ____ Cups/Day	Soda: ___ Glasses/Day	Chocolate: Per day ____ Month ____ Year ____	
Do you drink alcohol? ☐ Yes ☐ No		# Drinks _____ per day?	# Drinks _____ per week?	
Cigarettes/Nicotine? ☐ Yes ☐No	# of ____ Years	# Packs _____ per day?	Date you quit? _____	

BREAST MEDICAL HISTORY *(continued)*

Recreational Drugs? ☐ Yes ☐ No	# of _____ Years	Date you stopped? _____
Do you add salt to food when eating *and/or* cooking? ☐ Yes ☐ No		
Do You Exercise? ☐ Yes ☐ No	_____ Times Per Week	For _____ Minutes Per Sessions

PAST FAMILY HISTORY:

Disease	You	Relation	Disease	You	Relation
Breast Cancer	☐ Y ☐ N		Ovarian Cancer	☐ Y ☐ N	
BRCA Testing *(You or Family)* _____			Ashkenazi Jewish? _____		

PAST BREAST/OTHER SURGICAL HISTORY: Current BRA Size: _____

PREVIOUS NEEDLE BIOPSIES	SIDE	DATE	WHERE	DOCTOR	DIAGNOSIS

PREVIOUS NEEDLE BIOPSIES	SIDE	DATE	WHERE	DOCTOR	DIAGNOSIS

Previous Breast Problems?	

PAST SURGERIES	DATE	WHERE	DOCTOR

PLEASE CHECK ALL THAT APPLY:

Constitutional

☐ Weight Change ☐ Appetite Change ☐ Night Sweats
☐ Hot Flashes ☐ Fever Chills

Eyes, Ears, Nose, Mouth, Throat

☐ Double/Blurred Vision ☐ Nose bleeds ☐ Throat Problems
☐ Asthma ☐ Emphysema ☐ Shortness of breath ☐ Cough
☐ Wheezing ☐ Hx of Pneumonia ☐ Hx of Bronchitis

Neurological

☐ Headache ☐ Dizziness ☐ Weakness ☐ Numbness
☐ Stroke ☐ Seizures ☐ Fainting ☐ Migraines

Kidney, Bladder, Genital Problems

☐ Uterine ☐ Ovarian ☐ Change in menses
☐ Irreg bleeding ☐ Prostate disease ☐ UTI
☐ Kidney Disease/Stones ☐ Bladder infections/Frequency

Psychiatric

☐ Depression ☐ Anxiety

Gastrointestinal

☐ Difficulty swallowing ☐ Gas ☐ Pain ☐ Liver Disease
☐ Indigestion/Reflux ☐ Ulcers ☐ Colitis/IBS/Diarrhea

Cardiac/Respiratory

☐ Congestive Heart Failure ☐ Hx of Heart Attack
☐ Heart Murmur ☐ Mitral valve prolapse
☐ Circulation problems ☐ Blood clots

Musculo-Skeletal

☐ Bone Pain ☐ Joint Pain ☐ Leg Cramps

Skin

☐ Rash ☐ Lesions ☐ Abnormal Growths

Other

☐ Thyroid Problems ☐ Exposure To Toxic Chemicals
☐ Blood Disorders ☐ Infectious Diseases
☐ Travel Outside Of Country
Other _____

BREAST MEDICAL HISTORY *(continued)*

The following information is mandatory and of great importance in your continued care and treatment with this facility. This information will assist us in our quest to get you better and make your medical records more accurate. Thank you for your assistance.

First Name:	Last Name:	
Date of Birth:	Height:	Weight:

CHECK ONE: ARE YOU DIABETIC? ☐ Yes ☐ No	ARE YOU INSULIN DEPENDENT? ☐ Yes ☐ No
Preferred Pharmacy:	Pharmacy Phone #:
Pharmacy Address:	

MEDICATIONS LIST:

NAME	DOSE	HOW OFTEN	WHEN

ALLERGIES:

LATEX ALLERGY	REACTION	SEVERITY (MILD OR SEVERE)
☐ Yes ☐ No		
FOOD ALLERGIES	**REACTION**	**SEVERITY (MILD OR SEVERE)**
MEDICATION ALLERGIES	**REACTION**	**SEVERITY (MILD OR SEVERE)**

PLEASE LIST OTHER PHYSICIANS WHO CARE FOR YOU:

SPECIALTY	FIRST & LAST NAME	TOWN	PHONE NUMBER