

PATIENT INFORMATION FORM (MALE)

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ - _____ (plus 4)

EMAIL: _____

(IF YOU WOULD LIKE TO RECEIVE REMINDERS AND BILL VIA E-MAIL IN THE FUTURE)

PHONE#: (____) _____ - _____ WORK#: (____) _____ - _____ EXT: _____

CELL#: (____) _____ - _____

DATE OF BIRTH: ____/____/____ AGE: _____ SOCIAL SECURITY#: _____ - _____ - _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE #: (____) _____ - _____

RELATIONSHIP: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

NAME OF SPOUSE: _____

DATE OF BIRTH: ____/____/____ AGE: _____ SOCIAL SECURITY #: _____ - _____ - _____

SPOUSE'S EMPLOYER: _____

PHONE #: (____) _____ - _____

REASON FOR REFERRAL: _____

REFERRING PHYSICIAN: _____ PHONE #: (____) _____ - _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: (____) _____ - _____

PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

POLICY TYPE: HMO OR PPO

PRIMARY INSURED: _____ SSN #: _____ - _____ - _____

DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

POLICY#: _____ GROUP#: _____

PRIMARY INSURED: _____ SSN #: _____ - _____ - _____

DATE OF BIRTH: ___/___/___ RELATIONSHIP TO PATIENT: _____

I authorize the release of any medical information necessary to process an insurance claim for services rendered to me. Also, I authorize payment of medical benefits directly to CFBC for service to me. I accept full responsibility for my bill. I permit a copy of this authorization to be used in place of original. I certify that the information I have reported above is correct

SIGNATURE: _____ DATE: ___/___/___

CENTRAL FLORIDA BREAST CENTER MALE BREAST HISTORY

NAME: _____ DATE OF BIRTH: ___/___/___ TODAY'S DATE: ___/___/___

WHEN DID YOUR PRIMARY CARE PHYSICIAN LAST EXAMINE YOUR BREASTS? ___/___/___

WAS YOUR EXAM NORMAL? YES NO

IF NO, PLEASE EXPLAIN: _____

DO YOU HAVE A HISTORY OF TRAUMA TO THE BREAST? YES NO

IF YES, PLEASE EXPLAIN: _____

WHEN DID YOUR PRIMARY CARE PHYSICIAN LAST DO A TESTICULAR EXAM? ___/___/___

WAS THE EXAM NORMAL? YES NO

IF NO, PLEASE EXPLAIN: _____

DO YOU CONSUME CAFFEINATED BEVERAGES? YES NO APPROXIMATELY HOW MANY CUPS PER WEEK? _____

DO YOU CONSUME CHOCOLATE CONTAINING FOOD / BEVERAGES? YES NO QUANTITY PER WEEK? _____

HAVE YOU EVER HAD ANY SURGERY OR BIOPSY ON YOUR BREASTS? YES NO

IF YES, PLEASE EXPLAIN WHAT WAS DONE, ON WHICH BREAST, AND WHEN IT WAS DONE? _____

PROCEDURE	LEFT BREAST	RIGHT BREAST	DATE	DIAGNOSIS
Needle Core Biopsy			___/___/___	
Surgical Biopsy			___/___/___	
Other			___/___/___	

CENTRAL FLORIDA BREAST CENTER
PATIENT MEDICAL INFORMATION

NAME: _____

DATE: ___/___/___

PLEASE READ CAREFULLY AND CHECK ALL BOXES THAT APPLY:

HAVE YOU EVER HAD:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Meningitis/Encephalitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Blood Clots in Legs | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Heart Attack Abnormality | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Childhood Heart |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Peripheral Artery Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Murmur/Mitral Valve Prolapse | Do you require antibiotics prior to dental procedures? | <input type="checkbox"/> Sciatic Nerve Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Productive Cough | Do you require antibiotics prior to ALL procedures? | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> High Cholesterol/Triglycerides |
| <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anal Fistula or Fissure |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hernia | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Heartburn (Reflux) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Chronic Ulcerative Colitis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Pancreatic Disease Duodenal | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Ulcers: Stomach |
| <input type="checkbox"/> Abnormal Pap Smears | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS/ARC/HIV Positive | <input type="checkbox"/> Recent Change in Bowel Habits | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Problems with Anesthesia, specify: _____ |
| <input type="checkbox"/> Steroids or Prednisone Use | <input type="checkbox"/> History of Prostate Cancer | _____ |
| <input type="checkbox"/> Change in Vision | <input type="checkbox"/> Testicular Disorder | <input type="checkbox"/> Sciatic Nerve Pain |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> History of Testicular Masses | <input type="checkbox"/> Unexplained Fevers |
| <input type="checkbox"/> Bone Pain | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Anemia | |
| | <input type="checkbox"/> Significant Weight Loss | |
| | <input type="checkbox"/> Memory Loss | |
| | <input type="checkbox"/> Head Ache | |

PATIENT NAME: _____ DATE: ___/___/___

PAST SURGICAL HISTORY:

DO YOU HAVE ANY DRUG ALLERGIES? YES NO

IF YES PLEASE LIST: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

HAVE YOU EVER HAD CANCER? YES NO IF YES, WHAT TYPE? _____

CHEMOTHERAPY? YES NO RADIATION? YES NO

SOCIAL HISTORY:

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

OCCUPATION: _____

HAVE YOU EVER SMOKED? YES NO QUANTITY PER DAY? _____ LENGTH OF USAGE? _____

IF YOU HAVE QUIT SMOKING, HOW MANY YEARS AGO? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO APPROXIMATELY HOW MUCH PER WEEK? _____

LENGTH OF USAGE? _____

HAVE YOU EVER USED ILLICIT DRUGS? YES NO IF YES, DRUG USED: _____

HAVE YOU EVER USED BODY BUILDER SUPPLEMENTS? YES NO IF YES, DRUG USED: _____

DO YOU EXERCISE REGULARLY? YES NO HOW OFTEN? _____

LENGTH OF EXERCISE? _____

IF YOUR FAMILY HAS A HISTORY OF CANCER PLEASE INDICATE BELOW:

PLEASE ENTER THE RELATIONSHIP OF THE RELATIVE (I.E. GRANDMOTHER, MOTHER, SISTER, AUNT)

TYPE OF CANCER	RELATIONSHIP TO YOU	AGE OF ONSET:
Breast:		
Ovarian:		
Uterine:		
Cervical:		
Colon:		
Prostate:		
Pancreatic:		
Other:		

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are ultimately responsible for the entire bill of our service, unless other arrangements have been made with Central Florida Breast Center prior to your visit.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Central Florida Breast Center, if a balance is due.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Central Florida Breast Center, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection agency fees, and attorney fees.

Your insurance company has developed maximum fee schedule for rehabilitation and other services. These schedules are internal to your insurance company and they may or may not cover all charges incurred during your treatment. The fee schedules often do not reflect standard charges in our area. Please be advised that you are responsible for the total charges or any difference remaining following payment by your insurance company. If you do not feel your insurance company has made adequate payment on your account, please contact them to discuss this matter.

By signing below, you are agreeing to our Financial Policy and accept the responsibility of paying for your professional services rendered at Central Florida Breast Center.

I (print your name) _____, have read the above and fully understand the Financial Policy at Central Florida Breast Center, and am in agreement with the Financial Policy.

SIGNATURE OF PATIENT, GUARDIAN, OR CO-SIGNER: _____

WITNESS: _____

DATE: _____

DIRECTIONS TO DR. SACHEDINA'S OFFICE

(407) 740-5127

FROM I-4:

Take exit 87 (Fairbanks Ave): At the bottom of the ramp follow the signs for Winter Park. You will then be on Fairbanks Ave. Stay on Fairbanks Ave. It will change names and become Osceola, then Aloma. Go until you see a cross street called N. Lakemont; once at N. Lakemont you will drive another half of a block. On your right-hand side you will see a Tires Plus and a Regions Bank; in between these two buildings is a side-street, Strathy Lane – turn right. Once on Strathy Lane you will see our building, Glenwood Professional Center (pink, two story building). Turn left onto Glenwood and then right into our parking lot. We are located on the second floor.

FROM MAITLAND:

Take 436 (Semoran Blvd) south to Aloma Ave. Take a right. Once on Aloma you will go up three stoplights: Ranger, Balfour, and St. Andrews. Turn left onto St. Andrews. Glenwood will be the first street on your right. Turn right onto Glenwood and go up about a block. Our building will be the pink two story building on your left-hand side. We are located on the second floor.

FROM THE AIRPORT:

Take 436 (Semoran Blvd) north to Aloma Ave. Take a left. Once on Aloma you will go up three stoplights: Ranger, Balfour, and St. Andrews. Turn left onto St. Andrews. Glenwood will be the first street on your right. Turn right onto Glenwood and go up about a block. Our building will be the pink two story building on your left-hand side. We are located on the second floor.