Central Florida
Breast Center, P.A.

Dr. Shenin Sachedina,
D.O., FACOS

PATIENT INFORMATION FORM (FEMALE)

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 #: (___) _____ - _____

OBGYN: _____ 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: ____/____/_____

NP1 03/11

CENTRAL FLORIDA BREAST CENTER BREAST HISTORY

NAME: _____ DATE: ___/___/___

When did your Primary Care or GYN Last examine your breasts? ___/___/___

Age at first menstruation? _____

Have you begun Menopause? ☐ Yes ☐ No If yes, at what age? _____

Have you ever been pregnant? ☐ Yes ☐ No How many times have you been pregnant? _____

Please list:

# of Live Births_____ # of Miscarriages _____ # of Abortions _____ # of Still Births _____

# of Other _____

At what age did you have your first pregnancy? _____ Age at first delivery? _____

Did You Breast Feed: ☐ Yes ☐ No And / Or Bottle Feed: ☐ Yes ☐ No

What was the first day of your last menstrual period? ___/___/___

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
Breast Reduction			___/___/___	
Chemotherapy			___/___/___	
Cyst Aspiration			___/___/___	
Implants			___/___/___	
Lumpectomy/Radiation			___/___/___	
Mastectomy			___/___/___	
Needle Core Biopsy			___/___/___	
Surgical Biopsy			___/___/___	
Other			___/___/___	

Are you currently taking or have you ever taken Contraceptives? ☐ Yes ☐ No

If Yes, Name: _____ Length of usage? _____

Are you currently taking or have you taken Hormone Replacement therapy,

(such as, Estrogen, Progesterone, or Testosterone)? ☐ Yes ☐ No

If Yes, Name: _____ Length of usage? _____

CENTRAL FLORIDA BREAST CENTER

NAME: _____ DATE: ___/___/___

PLEASE READ CAREFULLY AND CHECK ALL BOXES THAT APPLY:
HAVE YOU EVER HAD:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Seizures
- ☐ Abnormal Heart Beat
- ☐ Heart Attack Abnormality
- ☐ High Blood Pressure
- ☐ Murmur/Mitral Valve Prolapse
- ☐ Asthma
- ☐ Productive Cough
- ☐ Diabetes Mellitus
- ☐ Skin Disorder
- ☐ Blood in Stool
- ☐ Crohn's Disease
- ☐ Heartburn (Reflux)
- ☐ Hiatal Hernia
- ☐ Pancreatic Disease Duodenal
- ☐ Abnormal Pap Smears
- ☐ Kidney Stones
- ☐ AIDS/ARC/HIV Positive
- ☐ Blood Disorder
- ☐ Steroids or Prednisone Use
- ☐ Change in Vision
- ☐ Nausea/Vomiting
- ☐ Head Ache
- ☐ Vaginal Bleeding not associated with Menstrual Cycle
- ☐ Ear Problems
- ☐ Hay Fever
- ☐ Sinusitis
- ☐ Blood Clots in Legs
- ☐ Heart Failure
- ☐ Peripheral Artery Disease

Do you require antibiotics prior to dental procedures?

☐ Yes ☐ No

Do you require antibiotics prior to ALL procedures?

☐ Yes ☐ No

- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Hernia
- ☐ Thyroid Disease
- ☐ Chronic Ulcerative Colitis
- ☐ Diverticulosis/Diverticulitis
- ☐ Hemorrhoids
- ☐ Irritable Bowel
- ☐ Recent Change in Bowel Habits
- ☐ Bladder Problems
- ☐ Prostate Enlargement
- ☐ Anemia
- ☐ Cancer
- ☐ Bone Pain
- ☐ Back Pain
- ☐ Significant Weight Loss
- ☐ Memory Loss
- ☐ Eye Problems
- ☐ Meningitis/Encephalitis
- ☐ Chest Pain
- ☐ Childhood Heart
- ☐ Rheumatic Fever
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ High Cholesterol/Triglycerides
- ☐ Anal Fistula or Fissure
- ☐ Colon Polyps
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Ulcers: Stomach
- ☐ Female Organ Disorder
- ☐ Venereal Disease
- ☐ Bleeding Problems
- ☐ Problems with Anesthesia, specify: _____

_____

- ☐ Sciatic Nerve Pain
- ☐ Abdominal Pain
- ☐ Unexplained Fevers

CENTRAL FLORIDA BREAST CENTER PATIENT MEDICAL INFORMATION

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: _____

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 lat. 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.