CHAND ROHATGI, M.D., F.A.C.S.

A PROFESSIONAL CORPORATION

THE BREAST CARE CENTER & GENERAL SURGERY PRACTICE
3735 NAZARETH ROAD, EASTON, PENNSYLVANIA 18045-1963
PHONE 610-252-1999 FAX 610-252-0573

Date: ____/____/____ Time: ________ am / pm

Name: ______________________ Gender: M /F D.O.B: ____/____/____ SS#: ____________ Marital Status: M/S/W/D

Address: ______________________________ City ____________________ State: ______ Zip: ________

Phone: ________________ Cell: ________________ Work: ________________ ext. # ____________

PCP: ______________ Gyn: ______________ Other (s): ______________ Referred by: ____________

Age: ____ Height: ______ Weight: ______ Race: __________ Occupation: ______________ Email ______________

Primary Insurance: ____________________ Policy #: ____________________ Group #: ____________

Subscriber ____________________ D.O.B.: ______________ S.S. #: ______________

What is the reason for your visit today? ____

What has been done for the problem so far? ____

Current or Past Medical History		Comments:
Liver Failure	Y / N	______________
Kidney Failure	Y / N	Dialysis Needed: Yes / No
Hepatitis or HIV (AIDS)	Y / N	______________
Thyroid or Adrenal Condition	Y / N	______________
Stroke, TIA, or Mini Strokes	Y / N	______________
Excessive Bleeding, Trouble Clotting, Easy Bruising	Y / N	______________
Cancer	Y / N	______________
Other Diseases (Communicable, TB)	Y / N	______________
Diabetes	Y / N	______________
Sleep Apnea	Y / N	CPAP Required: Yes / No
MRSA	Y / N	______________

Lifestyle / Social		Comments:	
Smoking	Y / N	# Daily ________	# of Years ________
Alcohol	Y / N	# Daily ________	# Weekly ________
Drugs (Including pain and street drugs)	Y / N	Type ________	# of Years ________

Neuropsychological		Comments:
Seizures or Convulsions	Y / N	______________
Dizziness, Fainting, Fatigue, Weakness	Y / N	______________

Cardiovascular		Comments:
Heart Disease	Y / N	______________
Heart Attack (MI) Or Congestive Heart Failure	Y / N	Date: ______________
Heart Surgery, Angioplasty, Stents, Catheterizations	Y / N	Date: ______________
Pacemaker of Defibrillator	Y / N	Date Implanted: ________ Brand: ________
High Blood Pressure	Y / N	______________
Low Blood Pressure	Y / N	______________
High Cholesterol	Y / N	______________
Low Cholesterol	Y / N	______________

Respiratory		Comments:
Asthma or Chronic Lung Disease	Y / N	______________
Cough / Wheezing	Y / N	______________
Pneumonia	Y / N	______________
Bronchitis	Y / N	______________
Difficulty breathing when lying down	Y / N	______________

Date of Visit										
Patient Initials										
Physician Initials										

Patient Name_______________________________ **D.O.B.**_____/_____/________

Gastrointestinal		**Comments:**
Nausea	Y / N	
Diarrhea	Y / N	
Constipation	Y / N	
Abdominal Pain	Y / N	
Gas / Belching	Y / N	
Indigestion	Y / N	
Hiatal Hernia, Reflux, or Stomach Ulcers	Y / N	

Female Use Only		**Comments:**
Any Possibility of Pregnancy	Y / N	Age of first Menstrual Period________
Last Normal Menstrual Period__________ Number of pregnancies______		Live Births______ Abortions_____ Miscarriages______
Do you or did you breast feed?	Y / N	
Do you perform regular breast self exams	Y / N	
Breast Pain	Y / N	When__ ________ For how long________
Nipple Discharge	Y / N	Color__________ For how long________
Breast Abscess; Infections	Y / N	
Have you ever taken birth control hormones (i.e. pill, patch, injection)	Y / N	
Are you currently taking birth control hormones	Y / N	Type________________
In total, how many years have you taken birth control hormones ______		
Have you ever taken medication to assist in getting pregnant?	Y / N	Type____________How many ________
Have you ever taken Hormone Replacement Therapy?	Y / N	
If so, how long were you taking HRT?		
Have you ever taken Tamoxifen	Y / N	For How Many Years__________

If yes, please circle one: For Treatment of cancer or DCIS or For Prevention of cancer.

Please list all previous surgical procedures (invasive and non-invasive)

____

____

____

Please list all Medications and Herbal Supplements both prescribed and/or over the counter that you take

Medication	Dosage	Frequency	Reason for taking	Medication	Dosage	Frequency	Reason for taking

Please list ALL medications, metals, dyes, latex, or food allergies and the reaction.

____

Additional Medical History

____

____

Do you have any dental or oral appliances, loose or capped teeth or body piercings? Y / N

Have you or any relatives ever had serious problems with anesthesia? Y / N

Do you have any special needs (cultural, physical, religious, medical, emotional, communication barrier)? Y / N

Have you had any recent blood work or EKG done within the last 30 days? Y / N Location: ______________

Date of Visit									
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Family History Questionnaire

Name: ______________________________ **D.O.B:** ______________

Are you of Ashkenazi Jewish ancestry? Yes_____ No_____
Have any men in your family been diagnosed with breast cancer? Yes_____ No____
If yes, how is he related to you? ____________________
Do you have any additional family members with cancer? If yes, please explain______________________

	Breast Cancer before 50	Breast Cancer after 50	Ovarian Cancer	Colon Cancer before 50	Colon Cancer after 50	Endometrial Cancer before 50	Endometrial Cancer after 50	Melanoma-multiple primary melanomas	Pancreatic Cancer	Other Cancers
Yourself										
Your Mother										
Your Father										
Your Sister(s)										
Your Brother(s)										
Your Daughter(s)										
Your Son(s)										
Mother's Side										
Grandmother										
Grandfather										
Aunt(s)										
Uncle (s)										
Cousin(s)										
Father's Side										
Grandmother										
Grandfather										
Aunt(s)										
Uncle (s)										
Cousin(s)										

***Updated Information is to be marked in appropriate box in red ink at time of yearly office visit, along with your initials in the space provided**

Date of Visit											
Patient Initials											
Physician Initials											

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Breast Cancer Risk Survey

Patient Name: ______________________ **D.O.B.:** __________

Patient Instructions:
While you are waiting to see the physician, we ask that you complete the survey below. It will help us to assess your risk for developing breast cancer. Thank You.

Have you ever had breast cancer? **[ ] Yes [ ] No**

If you checked "yes", you have completed this survey. Please give the survey to the physician.

1. What is your race? **[ ] White [ ] Black [ ] Asian**
2. Have you ever had a breast biopsy that showed lobular carcinoma in situ or ductal carcinoma in situ? **[ ] Yes [ ] No / Don't Know**
3. How old are you? ______
4. How old were you when you had your first menstrual period? ______
5. How old were you when your first child was born? ______
   (If you never had a child, enter "0")
6. How many of your sisters, daughters, or mother have had breast cancer ______
7. Have you ever had a breast biopsy? **[ ] Yes [ ] No/Don't Know**
   (A breast biopsy is when the doctor removes tissue from your breast to test for cancer)
   6a.) If yes, how many breast biopsies have you had? ______
   6b.) Did the doctor ever tell you that one of your biopsies showed atypical hyperplasia?
   (A precancerous condition) **[ ] Yes [ ] No [ ] Don't Know**

Pt. Initials: __________ **Date:** __________

__________**% 5 Years**
__________ **% Lifetime**

After the first initial completion of this form, the information is to be updated on a yearly basis. Please provide updated information in the space provided below for questions numbered 3, 6, and 7 in red ink, along with the date of visit and your initials.

Date of Visit	Patient Initials	Question #3	Question #6	Question #7	% 5 Years	% Lifetime	Physician Initials

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Patient Name: ______________________________ Date of Birth: __________

Communication Consent

It is the office policy of Chand Rohatgi M.D. F.A.C.S. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, cellphone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Chand Rohatgi M.D. F.A.C.S. and/or staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Mode of contact	Message can be left or not		
Home Telephone: ____________________	**Yes / No**	**Answering machine:**	**Yes / No**
Work Telephone: ____________________	**Yes / No**		
Cell Phone: ____________________	**Yes / No**		
Email Address: ____________________			

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996, you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you.

By completing this form you are informing Chand Rohatgi M.D., F.A.C.S. and staff of your wish to designate the named person(s) as your personal representative. You may revoke this designation at any time by signing and dating the revocation section of this form and returning it to the office.

I, ______________________________ (print name) hereby nominate the following person(s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me. This person(s) is to be afforded all the privileges that would be afforded to me with respect to my health information.

1.) ______________________ ______________________ Home: ______________
Print name of representative Relationship Cell: ______________
Work: ______________

2.) ______________________ ______________________ Home: ______________
Print name of representative Relationship Cell: ______________
Work: ______________

Signature: ______________________________ **Date:** ______________

Designation of Representative Revocation Section

I am hereby revoking the below mentioned representative(s) and/or am not designating a personal representative. I understood that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Chand Rohatgi M.D. F.A.C.S. I further understand that any such a revocation does not apply to the extent that person(s) authorized to use or disclose my health information have already acted in reliance of this designation.

Representative(s) being revoked: ______________________________

Signature: ______________________________ Date of Revocation: ______________

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Patient Name: ______________________________ Date of Birth: ______________

Financial Policy Signature on File

- ✓ I authorize use of this form on all my insurance submissions
- ✓ I authorize release of information to all my insurance companies
- ✓ I understand that I am responsible for my bill to Chand Rohatgi M.D., F.A.C.S.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my insurance company (s)
- ✓ I authorize payment directly to my doctor
- ✓ I permit a copy of this authorization to be used in place of the original

Patient's Medicare Authorization

"I, ______________________________request that payment of authorized Medicare benefits is made either to me or on my behalf to Chand Rohatgi M.D., F.A.C.S. for any services furnished to me by my physician or supplier. I authorize any holder of medical information about me to release to the HGS Administrators and its agents, any information needed to determine these benefits or the benefits payable for related services."

Notice of Privacy Policy & Practices

- ✓ I have received and reviewed the privacy policy information from Chand Rohatgi M.D., F.A.C.S.
- ✓ I acknowledge and consent to my Financial Policy Signature on File
- ✓ If applicable, I am giving Chand Rohatgi M.D., F.A.C.S. Medicare authorization
- ✓ I acknowledge and consent to Chand Rohatgi M.D., F.A.C.S. obtaining my Medication History

____

Signature Date