ST. Joseph's | Candler
Telfair Breast Surgery

PATIENT REGISTRATION

Comprehensive Oncology Services

PATIENT DEMOGRAPHIC INFORMATION

Last Name ____________________ First Name ____________________ Middle Name ____________________

Primary Address ____

City ____________________ State __________ Zipcode __________

Secondary Address ____

City ____________________ State __________ Zipcode __________

Primary Phone ____________________ ○ Home ○ CELL Second Phone ____________________ ○ Work ○ CELL

Email Address ____________________

Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Civil Union Spouse/ Partner Name ____________________

Your Birthdate ____________________ Your Gender ○ Female ○ Male Your SSN ____________________

Federal Government Required Data

Race ○ Native American / Alaskan ○ Asian / Asian Decent ○ Native Hawaiian / Pacific Islander ○ Black / African Decent ○ White / European Decent ○ More than one race ○ Other Please list: ____________________

Ethnicity ○ Hispanic ○ Non-Hispanic Language ○ English ○ Spanish ○ Other __________

Education Lvl ○ High School Diploma/GED ○ Some College ○ College Degree ○ Post Graduate Degree

Occupation ____________________ ○ Retired
Current or previous

Insurance Information

Insurance Coverage ○ YES ○ NO If yes, please present your original cards

Primary Insurance Company ____________________ Effective Date __________

Secondary Insurance Company ____________________ Insured SSN __________

Insured DOB ____/____/____ Insured Name ____________________

Contact Information

Referring Provider ____________________ Primary Care Provider ____________________

Emergency Contact ____________________ Relationship ____________________

Contact Phone # ____________________ Email Address ____________________

Please list up to three(3) people that are authorized to access your medical records

____________________ ____________________ ____________________

Office use :	Patient ID	TBS	MedOnc	RadOnc	GynOnc	MultiD	PalMed	CMOP	SAV	HHI	BLF

YOUR MEDICAL HISTORY

Name:______________________________ Date Form Completed:____________________

Date of Birth: ________________________ By Whom: ___________________________

Please check only information that applies.
When possible, if a date is required, please enter the date. If date is not known, please enter a year.
Your Medical Problems

Have you had the following:	Yes	Month/Date/Year
Alzheimer's		
Anemia		
Anxiety		
Asthma		
Atrial Fibrillation		
Bronchitis		
Cancer (any type) Please list type:		
Carotid Artery Disease		
Celiac Disease		
Cirrhosis		
COPD (Chronic Obstructive Pulmonary Disease)		
Clotting Disorder (Please list type)		
Congestive Heart Failure		
Depression		
Diabetes-Non Insulin Dependent (Type II)		
Diabetes-Insulin Dependent (Type I)		
Dialysis		
Diverticulitis		
DVT/Deep Vein Thrombosis		
Sleep Apnea Do you use a CPAP machine?		
Heart Attack		
Hyperlipidemia (High Cholesterol)		
Hypertension (High Blood Pressure)		
Hyperthyroidism (high)		
Hypothyroidism (low)		
Peripheral Vascular Disease (PVD)		
Gallstones		
Pneumonia		
Coronary Artery Disease		

Have you had the following:	Yes	Month/Date/Year
Kidney Disease		
Kidney Stones		
Lupus		
Lymphoma		
Malignant Hyperthermia		
Melanoma		
Reflux (GERD)		
Osteoarthritis (List Site)		
Osteopenia		
Osteoporosis		
Parkinson's Disease		
Peripheral Neuropathy		
Polycythemia Vera		
Pulmonary Embolus		
Seizures		
Sickle Cell Anemia		
Stroke		
Dementia		
Thrombocytosis		
Usual Childhood Illness (Measles, Mumps, Chicken Pox, etc.) Circle Applicable		

New Breast Complaints:

Breast Pain		☐ Right ☐ Left
Breast or Axillary Lump		☐ Right ☐ Left
Nipple Discharge		☐ Right ☐ Left
Change in breast size		☐ Right ☐ Left
Skin Changes		☐ Right ☐ Left
Nipple Inversion		☐ Right ☐ Left

Patient Initials______________

Your Surgical/Procedure History

	Yes	Month/Date/Year
Ablation(Please list procedure)		
AICD Placement		
Appendectomy		
Bone Marrow Aspiration/Biopsy		
Brain Surgery		
Breast Reduction		
Breast Biopsy- (Needle)		☐ Right ☐ Left
Breast Biopsy- (Surgical excision)		☐ Right ☐ Left
Breast Implant		
Bronchoscopy		
Caesarean Section		
Cataract Removal		
Central Line/ Port Placement		
Cholecystectomy		
Colonoscopy		
Colostomy		
Colectomy		
Coronary Artery Bypass		
Endoscopy, Upper		
Gamma Knife		
Hernia Repair		

	Yes	Month/Date/Year
Hysterectomy		
Oophorectomy (removal of ovaries)		
Joint Replacement		
Laminectomy		
Lobectomy		
Lumbar Puncture		
Lumpectomy		☐ Right ☐ Left
Mastectomy		☐ Right ☐ Left
Pacemaker Placement		
Paracentesis		
PEG Tube		
PET or PET/CT Scan		
Radiation		
Radiation Seeds		
Thoracentesis		
Tonsillectomy		
Tubal Ligation		
Whipple		
Transplant (specify type)		
Coronary stents		

Gynecologic History	
Number of Pregnancies:	
Number of live births:	
Your Age at First Birth:	
Interrupted Pregnancies	
Menses	
Age at first Menstrual Cycle	
Last Menstrual Cycle (Date)	
Menstrual Cycle Length	
Current Gyn Physician	
Removal of Ovaries (date)	

Circle your current Menopausal Status:
Pre Peri Post Unknown

Reason for Menopause: (circle one) Age at Menopause: _______
Chemo Surgical
Natural Other

Last PAP (date)	
History of Abnormal Pap	Yes / No #Years
Last Mammogram (date)	
Any Hormone Use:	Yes / No
Contraceptive Hormone Use	Yes / No # Years:
Post Menopause Use	Yes / No # Years:
Other Hormone Use	Yes / No # Years:

How many children did you breast feed?	
How long did you breast feed?	

Patient Initials______________

Your Family History of CANCER

Do you have a history of BREAST CANCER or OVARIAN CANCER in your family?							
		Breast Cancer	Ovarian Cancer	Pancreatic Cancer	Other Cancer	Age at time of cancer diagnosis:	Age at death:
Mother							
Maternal Grandmother							
Maternal Grandfather							
Maternal Aunt							
Maternal Uncle							
Father							
Paternal Grandmother							
Paternal Grandfather							
Paternal Aunt							
Paternal Uncle							
Sister							
Brother							
Daughter							
Son							
First Cousins							
Other relative							

Do you have an Ashkenazi Jewish ancestry in your family? ☐ Yes ☐ No

Have you, or any of your family members, ever tested positive for a BRCA 1 or BRCA 2 gene mutation? ☐ Yes ☐ No

Please list any other known gene mutations that have been detected in a blood relative:____________________

Your Social History/Personal Environment

☐ Drives Independently	☐ Utilizes Transport Assist by Public Transport	☐ Utilizes Family/Friends for transportation
Support System: ☐ Lives with Others ☐ Alone ☐ Nursing Home	☐ Assisted Living ☐ Incarcerated	☐ Homeless

Smoking History

Have you **ever** smoked? Yes____ No____	Currently smoke every day? Yes____ No____	Currently smoke some days? Yes____ No____	Did you smoke but quit? Yes____ No____
How many years have you smoked? ______		How many Packs per day? _______	Number of years quit? ______
Do you use recreational drugs? Yes___ No___ If yes, please list:		Do you use other tobacco products? Yes ____ No ____ Chewing tobacco _____ Snuff ____ Cigars_____ Pipe ____	

Alcohol Consumption:

Currently drink everyday	Yes____	No____	How many drinks a day do you drink? ______
Currently drink some days	Yes____	No____	How many days a week do you drink? ______
Used to drink, but quit	Yes____	No____	How many years since you quit? ______
Never	Yes____	No____	

Patient Initials______________

Have you been exposed to Hazardous Materials?
☐ Asbestos ☐ Benzene ☐ Chemotherapy ☐ Lead ☐ Radiation
☐ Other Petroleum Products ☐ Pesticides ☐ Agent Orange ☐ Other

Infectious Diseases

Infectious Diseases	Yes	Date/Month/Year
Hepatitis A B or C		
HIV		
AIDS		
MRSA		
Tuberculosis		
HPV		
STD		
Other		

Currently Implanted Medical Devices

Medical Devices	Yes	Month/Date/Year
Central Line Catheter (PortaCath,Groshong, Hickman, PICC)		
Dialysis Catheter		
Artificial Joints		
Drain (Type and Site)		
Heart Valve		
Pacemaker/ AICD		
Urinary Catheter		

Performance Status

Please choose only one:
☐ 0- Able to carry on all activities without restriction.
☐ 1- Able to perform most physical activities, e.g. light house or office work, but not strenuous activities.
☐ 2- Up and moving around for more than 50% of waking hours; able to care for self, but not able to work.
☐ 3- Confined to bed or chair for more than 50% of waking hours; Capable of only limited self-care.
☐ 4- Can not carry out self-care. Totally confined to bed or chair.
Assistive Devices: ☐ Crutches ☐ Wheelchair ☐ Cane ☐ Walker ☐Hearing Aide

Nutrition

	YES	DESCRIBE
Regular Meals		
Nutritional Supplements		
Diabetic Diet		
Unintended Weight Loss		
Other (List)		

- **Have you ever received a blood transfusion?** ☐Yes ☐No
- **Would you accept a blood transfusion, if it became necessary, to save your life?** ☐Yes ☐ No

Patient Initials______________

Allergies

☐ I have no known drug allergies.

Medication/Drug Allergies:	Reaction Type		Are you allergic to the following?	Reaction Type
		☐	Dairy	
		☐	Gluten	
		☐	Iodine	
		☐	Latex	
		☐	MSG	
		☐	Nuts	
		☐	Shellfish	
		☐	Tape	
		☐	Band Aids	
		☐	Other	

Please List Current Prescription Medications/ Over the counter medications/ Vitamins/ Herbal Supplements:

Medication/Supplement Name	Dose	How Often?	When Started? Date/Year	Reason for Medication

Patient Initials_______________

Preferred Pharmacy:____ Phone #:_________________

Pharmacy Location:____

Preferred Lab:_________________________ Preference required by Insurance?_________________________

Any Additional Information:____

We are committed to providing excellent service in a timely manner. Your responsibility as a patient is to attend your appointments and communicate any changes in your schedule that will prevent you from keeping your scheduled appointment. Our goal is to have your physician/provider see you within 30 minutes of your appointment time. If you are not seen within 30 minutes, you are encouraged to inform our staff. Patients arriving late for appointments will be triaged based upon their medical condition, offered the opportunity to wait while they are worked into the schedule, or to be rescheduled. Appointments cannot be moved up for patients arriving early.

TELEMEDICINE PATIENT CONSENT FORM

PATIENT NAME: ________________________________ DATE OF BIRTH: ______________

1. **PURPOSE**: The purpose of this Form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s):

   ____

   ____

2. **NATURE OF TELEMEDICINE CONSULT**: During the telemedicine consultation (i) details of your medical history, examinations, x-rays, and tests will be discussed with healthcare providers through the use of interactive video, audio and telecommunication technology; (ii) a physical examination of you may take place; (iii) a non-medical technician or others may be present to assist in the transmission of video, audio or telecommunication; (iv) video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s). By signing this Form, I hereby authorize the electronic transmission of my medical information and/or video conference session so that it can be viewed by a healthcare provider and/or other persons involved in my care.
3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, however, that not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine consultation to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation. I further acknowledge that I have been offered a copy of my healthcare provider's Notice of Privacy Practices.
5. **RIGHTS**: I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons.
6. **DISPUTES**: You agree that any dispute arising out of the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all such disputes.
7. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences and benefits of telemedicine, including the risks of technological interruption, unauthorized access and technical difficulties. You further expressly acknowledge that the telemedicine consultation will not be the same as an in-person visit and that your healthcare provider has discussed with you the information provided herein and above. You have had the opportunity to ask questions about the information presented on this Form and the telemedicine consultation. All of your questions have been answered and you fully understand the written information provided above.

Signature of Patient (or Legal Representative): ________________________________

Print Name: ________________________ Date: ______________ Time: ______________

Signature of Witness: ____

Print Name: ________________________ Date: ______________ Time: ______________

Nancy N. and J.C.
Lewis Cancer
& Research Pavilion
at St. Joseph's/Candler

Nancy N. and J.C.
Lewis Cancer & Researh Pavilion
225 Candler Dr, Savannah GA 31405

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2** for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3** for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4** for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance officer in person at 5353 Reynolds Ave, Savannah, GA 31405 or by phone at 912-819-5291.