Breast Cancer Surgeons of Texas

Terre Q. McGlothin
6020 W. Parker Road, Suite 440
Plano, TX 75093
P: 469.661.2278 F: 469863.7036

PATIENT REGISTRATION FORM

NAME: _____ AGE: _____

REASON FOR VISIT: _____ REFERRED BY:_____

Yes **No** *Please Check **Yes** or **No***

☐ ☐ Have you been diagnosed with breast cancer? Date? _____

☐ ☐ Do you have lumps in your breast? If so: How and when were they discovered? _____

☐ ☐ Have you had a mammogram? Date? _____ Findings? _____

☐ ☐ Do you practice breast self-examination regularly?

☐ ☐ Do you have breast implants?

☐ ☐ Discharge from nipples? Left ☐ Right ☐ How long? _____ Color? _____

☐ ☐ Previous breast surgery/biopsy? Left ☐ Right ☐ Date? _____

List previous breast surgery/biopsy with dates. _____

_____

☐ ☐ Other Surgeries? List: _____

☐ ☐ Drug or other allergies? List: _____

☐ ☐ Prescribed Medications? List: _____

☐ ☐ Do you take any weight loss medication? List: _____

☐ ☐ Do you take aspirin/blood thinners regularly? How many per day: _____

☐ ☐ Have you ever or do you currently take Birth control, Progesterone, Estrogen, Thyroid or Cortisone?

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NAME: _____ AGE: _____

Yes **No** *Please Check **Yes** or **No***

☐☐ Are you Pregnant? Number of Pregnancies? _____ Live Births? _____
Age of first pregnancy? _____ Age of last pregnancy? _____

☐☐ Did you breast feed? How many years? _____

☐☐ Do you menstruate? Last period? _____ Age of first menstrual cycle? _____

☐☐ Have you had a hysterectomy? Date? _____ Have your ovaries been removed? _____

☐☐ Do you drink caffeine beverages? How many glasses a day? Coffee:_____ Tea:_____ Soda:_____

☐☐ Do you smoke? If so: How many per day? _____

☐☐ Do you drink alcohol? How many glasses a week? Beer:_____ Liquor:_____ Wine: _____

List family history of ***Breast cancer*** and age of diagnosis (Maternal/Paternal):

_____

_____

_____

List **other** family history of cancer and age of diagnosis (Maternal/Paternal):

_____

_____

_____

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NEW PATIENT INFORMATION

DATE: _____

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ ZIP:_____

PHONE (CELL): _____ PHONE (HOME): _____ PHONE (OTHER) _____

EMAIL ADDRESS: _____@_____ Can we send you emails? Yes/No

EMERGENCY CONTACT: _____ PHONE: _____

REFERRED BY: _____ PHONE: _____

REASON FOR REFERRAL/DIAGNOSIS: _____

IMAGING, DIAGNOSTIC TEST OR PROCEDURES PERFORMED TO DATE: _____

_____

PRIMARY INSURANCE: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____

DOB: _____ SS#: _____

ID: _____ GROUP: _____

EMPLOYER: _____

By signing this you are allowing Dr. Terre Q. McGlothin to bill your insurance for your visit here today, and any procedures performed here in the office or at the surgery center.

SIGNATURE: _____ DATE: _____

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PROTECTED HEALTH INFORMATION & NOTICE OF PRIVACY PRACTICE

I am confirming receipt of this Acknowledgement of Review of Privacy Practices, Patient Information and identifying who has access to my PHI, other than myself.

Please initial:

____ Only people listed below can have access to my PHI.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

____ The patient is under 18 years old and the legal representative has access to PHI and the legal representative is signing below.

____ You can leave a detailed message on the phone number provided; thus including dates, times, insurance benefits, medical information and results.

Circle which number you prefer if you have provided more than one number – Cell, Home, Work

_____ _____

Signature of Patient/ or Legal Representative if Patient is a MINOR Date

IF PATIENT IS A MINOR:

_____ _____

Print Name of Legal Representative Relationship

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I, _____ authorize the release of the indicated medical records for my continued care.

_____ Labs

_____ Radiology

_____ Pathology

_____ Other: _____

_____ ALL

Please forward to: Terre Q. McGlothin, MD
6300 W. Parker Rd
MOB 2 Suite 423
Plano, TX 75093
Fax: 972-981-3502

Name (Print): _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

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NO SHOW POLICY

Patients who fail to cancel or reschedule their appointment within 24 hours of their appointment time will incur a $35.00 fee. This policy will help to ensure that patients who are in immediate need of appointments have an opportunity to be seen in your cancelled appointment time.

Failure to show for an appointment three consecutive occasions will result in dismissal from the practice. The patient will be billed the no show fee of $35.00 for each missed appointment.

Thank you for your cooperation,

Terre Q. McGlothin, MD

I have read and understand the "No Show" policy as stated above.

_____
Patient's Name (Print)

_____ _____
Patient's signature Date

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SURGERY
CANCELLATION POLICY

We take pride in the appropriate reservation of your procedural date and time. Surgery scheduling, requires careful planning and coordination between our office, the Surgery Center and their operating room staff, as well as the anesthesiologist. In addition, special medical instrumentation is prepared and sterilized for each individual procedure. Therefore, please understand the importance of respecting our "Cancellation Policy" which entails the following:

Patients who cancel or reschedule their surgery within 72 hours of their scheduled time will incur a $150.00 fee. This policy will help to ensure that patients who are in immediate need of a surgical procedure have an opportunity to be scheduled.

Thank you for your cooperation,

Terre Q. McGlothin, MD

Name (Print): _____ Date of Birth: _____

Signature of Patient: _____ Date: _____