



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?

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):

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. McGlothlin to bill your insurance for your visit here today, and any procedures performed here in the office or at the surgery center.

SIGNATURE: _____ DATE: _____

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

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. McGlothlin, 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: _____

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. McGlothlin, MD

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

Patient's Name (Print)

Patient's signature

Date