THE OKLAHOMA BREAST CENTER

We would like to take this opportunity to welcome you to The Oklahoma Breast Center. We strive to meet all of your breast needs and provide you with the highest quality care. Your satisfaction is our goal. We are pleased you have chosen us for your surgical needs. The following information is provided to help you have the best experience at our clinic:

Your appointment is scheduled for:

_____

Day Date Time

We ask that you arrive <u>30 minutes</u> prior to your scheduled appointment time.

Your appointment is scheduled at:

☐ 3440 RC Luttrell Drive, Suite 102
Norman, OK 73072

☐ 13100 N Western Ave, Suite 200
Oklahoma City, OK 73114

☐ VIRTUAL VISIT

If you are scheduled for a virtual visit, please complete this paperwork and submit back to our clinic one day prior to your scheduled appointment.

Please bring to your appointment:

- The completed medical history form found in this packet.
- A list of your medications, including vitamins, over-the-counter and herbal medications.
- Your identification (Driver's License or photo ID)
- Your insurance(s) cards
- If your insurance requires a copayment, please be prepared to make that payment at the beginning of your appointment.
- Medical records from previous physicians that are important for your care

Our telephone number is: (405) 307-2623

Office hours are: Monday through Thursday 8:00 a.m. to 5:00 p.m.
Friday 8:00 a.m. to 12:00 pm

As part of our ongoing quality assessment and improvement activities, we survey our patients to learn about their experiences here. Your comments and suggestions about your visit will help us evaluate our services, and understand how we might improve your experience. You may receive our survey by mail or email. Your feedback will help us to improve the quality of care that we provide to you, your family, friends and neighbors.

We look forward to seeing you soon!

Denise Rable, M.D., F.A.C.S.
Jeneice Miller, APRN-CNP
The Oklahoma Breast Center

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Dear Patient:

We are dedicated to providing the highest quality, most cost-effective services available. We also attempt to make accessing our services as easy and hassle free as possible. The following represents our policy relative to payment services.

1. **Insurances:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility.

   Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments, Deductibles, and Co-Insurance:** All co-payments, deductibles, and co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles, co-insurances from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-Covered services:** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurances. You must pay for these services in full at the time of your visit.

4. **Authorization:** We will contact your insurance company for pre-certification of tests and surgery that our physician has recommended. It is your responsibility to let us know of any changes of coverage and anything required by your insurance carrier plan prior to services being rendered.

5. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your identification and current valid proof of insurance coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

6. **Claims submission:** We will submit your claims and assist you in any way possible to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company, we are not third party to the contract.

7. **Coverage changes:** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive the maximum benefits.

_____ _____

Signature Date

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Your Birth Date: _____ Current Age: _____

Pharmacy Name & Phone:_____

Primary Care Physician: _____ Referring Physician: _____

Reason for Today's Visit: _____

Date of Most Recent Mammogram: _____ Where was it performed? _____

Please review the list below and check any symptoms that apply to you:

General: Fever_____ Weight Change_____ Fatigue_____ Sweats_____ Generalized Weakness_____

Head: Headache_____ Change in Vision: ____ Sore Throat_____ Nosebleeds_____ Hoarseness_____

Breast/GYN: Breast Mass____ Nipple Discharge_____ Redness_____ Abscess_____ Breast Pain_____

Ovaries Remain? Y N Do you still have Periods: Y N When was your last period? _____

Respiratory: Chronic Cough_____ Productive Cough_____ Shortness of Breath_____ Wheezing_____

Cardiac: Chest Pain_____ Irregular/Rapid Heartbeat_____ Swelling in Legs_____

GI: Reflux____ Loss of Appetite____ Nausea____ Constipation____ Diarrhea____ Blood in Stools___

Musculoskeletal: Limited Range of Motion_____ Extremity Weakness_____ Joint Pain_____

Neurologic: Memory Impairment_____ Seizure_____ Dizziness_____ Blackouts_____ Paralysis_____

Urinary: Frequent Urination_____ Burning with Urination____ Blood in Urine____ Incontinence_____

Hem/Lymph: Difficulty Clotting_____ Swollen Lymph Nodes_____

Skin: Jaundice_____ Recurrent Skin Infections_____ Open Wound_____ Rash_____

Psychiatric: Depression_____ Mood Swings_____ Anxiety_____

Other Symptoms: _____

Office Use: Ht: _____ Wt:_____ T:_____ BP:_____ HR:_____ RR:_____

Personal Medical History *(please check all that apply to you)*:

_____ Heart disease _____ Lung disease _____ Stroke _____ Blood clots/use of blood thinners

_____High BP _____Diabetes ____ Kidney disease _____Liver disease

_____ History of Cancer (type:_____)

_____Other_____

Previous Surgeries and Dates: _____

_____

_____

Social History:

Occupation: _____ Marital Status: Married___ Single___ Divorced___ Widowed___

Are you a **Current Smoker**? Yes No If Yes, How many Packs/Day? ____ How Many Years? _____

Are you a **Previous Smoker**? Yes No (Circle One)

If Yes, When did you stop? _____ How Many Packs/Day?_____ For How Many Years?_____

Alcohol Use Yes No (Circle One) If Yes, How many drinks/week: _____

Family History & Member Affected:

Are you adopted? Yes No

Heart Disease: Yes No Relation: _____

Diabetes: Yes No Relation: _____

High BP: Yes No Relation: _____

Stroke: Yes No Relation: _____

Breast Cancer: Yes No Relation: _____

Ovarian Cancer: Yes No Relation: _____

Other Cancer: Yes No Relation: _____

Medications:

If there is no attached list, please list all medications you are taking currently, including over the counter and herbal remedies. Please include dosage and number of times a day the medication is taken if known.

Medication Name	Dosage (mg, cc, etc)	Frequency (how often)

Medication Allergies and Reactions:

Drug:_____ **Reaction:**_____

Drug:_____ **Reaction:**_____

Drug:_____ **Reaction:**_____

Drug:_____ **Reaction:**_____

Are you allergic to Latex? Yes No

High Risk Breast Cancer Questionnaire

INITIALS: _____

In order to more accurately estimate your breast cancer risk please complete the following questionnaire.

Patient Information

NAME		
CURRENT AGE	HEIGHT	WEIGHT
RACE	Are you of Ashkenazi-Jewish ancestry? YES ☐ NO ☐	

At what age did you start your periods? _____

How many children have you given birth to? _____ How old were you when you had your first child? _____

Are you? (select one) Pre-menopause ☐ Postmenopause ☐ (at what age? _____)

Have you had a Hysterectomy? YES ☐ NO ☐ Age _____

Have you had your Ovaries Removed? YES ☐ NO ☐ Age _____

Personal History of Breast Cancer YES ☐ NO ☐ Age _____

If you have had a breast biopsy, was it one of the following:

Hyperplasia ☐ Atypical Hyperplasia ☐ Lobular Carcinoma in Situ ☐ Other ☐ _____

Do you have personal history of Ovarian Cancer? YES ☐ NO ☐ Age _____

Do you have relatives who have had **OVARIAN CANCER?**			
RELATIONSHIP MATERNAL ☐ PATERNAL ☐ AGE AT DX___		RELATIONSHIP MATERNAL ☐ PATERNAL ☐ AGE AT DX___	
Do you have relatives who have had **PANCREATIC CANCER?**			
RELATIONSHIP MATERNAL ☐ PATERNAL ☐ AGE AT DX___		RELATIONSHIP MATERNAL ☐ PATERNAL ☐ AGE AT DX___	
Do you have relatives who have had **PROSTATE CANCER?**			
RELATIONSHIP MATERNAL ☐ PATERNAL ☐ AGE AT DX___		RELATIONSHIP MATERNAL ☐ PATERNAL ☐ AGE AT DX___	
Do you have relatives who have had **BREAST CANCER?**			
MOTHER	AGE	BILATERAL YES ☐ NO ☐	
DAUGHTER	AGE	BILATERAL YES ☐ NO ☐	
SISTER	AGE	BILATERAL YES ☐ NO ☐	
MATERNAL GRANDMOTHER	AGE	PATERNAL GRANDMOTHER	AGE
MATERNAL AUNT	AGE	PATERNAL AUNT	AGE
MATERNAL AUNT	AGE	PATERNAL AUNT	AGE
NIECE	AGE	MALE	AGE
1ST COUSIN	AGE		AGE
	AGE		AGE

Any family history of Triple Negative (ER negative, PR negative, HER2 negative) Breast Cancer? If so, who? _____

Have you ever used HORMONE REPLACEMENT THERAPY (HRT)?: ☐ YES ☐ NO

If yes, select one: Estrogen Only ☐ ☐ Combined Estrogen/Progesterone HRT

When did you last use HRT? _____ How many years did you use HRT? _____

If currently on HRT, how much longer do you intend to use HRT? _____

Have you or any of your relatives had hereditary cancer testing (*BRCA*)? YES ☐ NO ☐

Relationship to Patient? _____ What were the results of the testing? _____

PATIENT SIGNATURE _____ DATE _____