XRANM
Breast Surgery Associates at Santa Fe
435 St. Michael's Drive Suite A104 Santa Fe, NM 87505
General Information: (505) 372-1052 Fax: (505) 820-3172

Breast Surgery Associates of New Mexico
101 Hospital Loop NE, Suite 106 Albuquerque, NM 87109 General Information: (505) 828-0404 Fax: (505) 323-4331

PCP:_____Phone:_____GYN:_____phone:_____
Other Doctors_____
_____
_____
_____

Patient full name: _____DOB:_____
Age:_____Sex: _____ Marital status _____SS#_____Email:_____
Address: _____City: _____ State: _____ Zip:_____
Home Phone: _____ Cell phone: _____Work Phone:_____
Employer (required): _____ Address: _____
Spouse Name: _____ DOB: _____ SS#_____
Phone#_____ Employer (required)_____Work Phone_____
Address: _____
Emergency contact: _____Phone_____
How will you pay for today's services: ____ self-pay (due at time of service)_____ insurance_____ other_____

Person financially responsible for this account if other than patient:

Name: _____DOB: _____ SS#_____
Phone #_____ Primary Insurance:_____
Phone # (on card): _____Address (on card) _____
City/State: _____Zip: _____
ID#:_____Group#_____
Policy holder:_____DOB:_____Employer(required):_____
Secondary Insurance:_____ Phone # (on card): _____
Address (on card) _____City/State: _____Zip: _____
ID#:_____ Group#_____
Policy holder:_____ DOB:_____Employer(required):_____

I authorize XRANM to perform diagnostic procedures and treatment as may be necessary for proper medical care.

FINANCIAL AGREEMENT AND INFORMATION RELEASE

I hereby assign all medical and/or surgical benefits, to include Major Medical benefits to which I am entitled, including Medicare, and other government sponsored programs, private insurance and any other health plans. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not paid by said insurance. Further, I understand that I am responsible for payment of all reasonable collection fees and any associated legal costs incurred in the collection of any past due account balance. I hereby authorize assignee to release all information necessary to secure the payment of said benefits.

Patient/parent Guardian Signature:_____Date:_____
Date of Visit: _____ Patient Name: _____ DOB:_____

BREAST HEALTH HISTORY

Please write clearly

Reason for current visit: _____

Characteristics of the problem: _____

Location: _____Duration:_____

Nature of symptoms: _____

Do the symptoms change with your menstrual cycle/how? _____

Are there skin changes? _____ Are there Nipple Changes? _____

Are there changes to your mammograms/How? _____

Where have you had your previous mammograms? _____

What are your concerns/questions about this problem? _____

List all previous Breast problems/surgery/biopsy's you have had (if any): _____

_____

Have you had a history of radiation to the chest between the ages of 10 and 30? _____

Do you have Breast implants? _____ Indicate type and duration (if known): _____

Bra size: _____ Last menstrual period: _____ #of pregnancies: _____ #of Deliveries: _____

How old were you when you had your first menstrual period? _____

How old were you when you had your first live birth? _____

What type of birth control do you use? _____

Have you taken any of the following medications for more than 3 months?

	Duration	Last Taken
Birth control pills: _____	_____	_____
Hormone Replacement Therapy: _____	_____	_____

List all Allergies (including medication allergies): _____

_____ Latex Allergy? _____

List all of your Current medications: _____

_____

Do you use recreational drugs not prescribed by a physician? _____

Do you drink alcohol? _____How many drinks per week? _____

Do you smoke? _____How many packs per day? _____ How many years? _____

List all outpatients' surgeries you have had: _____

_____

List all inpatient surgeries you have had: _____

_____

List all hospitalizations you have had that did not involve surgery:_____

_____

_____

CURRENT MEDICAL PROBLEMS:

Do you have any of the following problems? Please check all that apply and describe.

- ☐ Bleeding problems _____
- ☐ Clotting problems _____
- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ HIV/AIDS _____
- ☐ High Cholesterol _____
- ☐ Skin Cancer _____
- ☐ Head or Neck Cancer _____
- ☐ Thyroid problems _____
- ☐ Asthma _____
- ☐ COPD _____
- ☐ Angina _____
- ☐ CHF_____
- ☐ Ulcers _____
- ☐ Hepatitis _____
- ☐ Kidney Problems _____
- ☐ Arthritis _____
- ☐ Lupus or Connective Tissue Problems _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Depression/Anxiety/Mental illness_____
- ☐ Anesthesia problems _____
- ☐ Any others not listed _____

FAMILY HISTORY

Race/Ethnicity**:** _____ Are you Ashkenazi Jewish (increased risk for breast cancer)? _____

Family members with the following problems (check all that apply)

	You	Mom	Dad	M/Aunt	P/Aunt	MGM	PGM	Siblings
Nipple discharge	☐	☐	☐	☐	☐	☐	☐	☐
Breast biopsy	☐	☐	☐	☐	☐	☐	☐	☐
Abnormal cells in breast	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Lymphoma	☐	☐	☐	☐	☐	☐	☐	☐
Gastrointestinal cancer	☐	☐	☐	☐	☐	☐	☐	☐
Mastectomy	☐	☐	☐	☐	☐	☐	☐	☐
Fertility treatments	☐	☐	☐	☐	☐	☐	☐	☐
DES Exposure	☐	☐	☐	☐	☐	☐	☐	☐

Medical problems of your father: _____

_____

Medical problems of you mother: _____

_____

Medical problems of your siblings: _____

_____

Other serious family health problems:_____

Acknowledgement of Receipt of Notice

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I hereby acknowledge that I read a copy of this medical practice's HIPAA

patient's rights.

I would like to receive a copy of any amended Notice of Privacy Practices by sending a request to the Privacy Officer at the above address and phone number. Yes ◯ No ◯

Signed: _____ Date _____ Printed name _____
Telephone: _____

If not signed by patient indicate relationship to patient:

Parent or guardian of minor patient
◯ Guardian or conservator of an incompetent patient
◯ Beneficiary or personal representative of deceased patient
◯ Name of Patient: _____

For office use only:

Signed form received by: _____ Acknowledgement refused:

Efforts obtained/reason for refusal: _____

RECORDS RELEASE AUTHORIZATION

I, _____ hereby authorize the release of all medical records:

To:

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To: Any and all l providers necessary for the continuation my care (to include Doctors and Facilities)

To: Any doctors listed below for correspondence

To: The following people: _____

_____

Patient Name: _____

DOB: _____

Patient Signature: _____

Date: _____

Witnessed: _____

Addresses required for correspondence:

Primary Care Physician:

_____
_____
_____

Gynecologist:

_____
_____
_____

Other Physicians/Specialists:

_____
_____
_____

Other Physicians/Specialists:

_____
_____
_____

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Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, the patient is responsible to present an insurance card or update any changes to their primary and secondary insurance in order to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If you require a referral please note, referrals are PATIENT RESPONSIBILITY.

Your applicable payment or co-payment for services is due at the time services are rendered. We accept cash, check, MasterCard, Visa, or Discover Card. Any returned checks from your bank due to insufficient funds will be assessed a $50.00 fee plus your balance.

Missed Appointment and Cancellations

Our office charges a **$75.00** fee for missed appointments and late cancellations. We give a **COURTESY** appointment reminder call 24-48 hours in advance, but we are **NOT** responsible for remembering your appointment, **YOU ARE!** Therefore, if we have any technical

difficulties, we will still charge you, as we just give **COURTESY** phone calls and you are ultimately responsible for your appointment.

For cancellations and reschedules, you must provide a **24-hour notice** or you will be charged a missed appointment fee. This fee must be paid prior to your next visit. If you arrive late to your appointment, we reserve the right to reschedule your appointment and charge a missed appointment fee.

In the event an account is placed in collection status, the account would need to be paid in full prior to scheduling any future appointments.

_____ _____

Signature of Patient/Responsible party Date