PARADISE COAST
BREAST SPECIALISTS

TROY SHELL-MASOURAS, MD

New Patient Information

Name _____ Gender_____ DOB_____

Age_____ Height_____ Weight_____ Bra size_____ Cup size _____

Address _____ Home phone _____

_____

_____ Mobile phone _____

Email _____

Would you like access to our patient portal? ____Yes ____No

Emergency contact _____

Relationship to patient_____ Phone number _____

Primary Care Physician _____

OBGYN _____

Referring Doctor _____

All other physicians_____

_____

_____

Reason for referral _____

_____

Last Mammogram_____ Where?_____

Breast MRI _____ Where? _____

Breast Ultrasound_____ Where?_____

Please list all breast imaging in the past (include year and location of imaging):

_____

_____

_____

Preferred pharmacy/phone number _____

Allergies (include medications and reaction):

_____

_____

PAST MEDICAL HISTORY

Please check all that apply to you:

__Diabetes	__Migraine headaches	__Heart attack
__Breast cancer	__Asthma	__Psychiatric illness
__Anesthesia problems	__Stroke	__Thyroid disease
__Anxiety/depression	__High blood pressure	__Bleeding disorders

Do you currently use blood thinners (if so, which one?)_____
Have you ever had any problems or complications with anesthesia?_____
_____

Please list any other medical conditions_____
_____

SOCIAL HISTORY

Do you use tobacco?_____ Amount per day _____How many years_____
Former tobacco user?_____ How many years?_____ What year did you quit? _____
Do you consume alcohol? _____How often?_____
Do you use caffeine? _____ How much caffeine daily?_____
Marital status_____ Occupation _____

GYN HISTORY

At what age did you start your period?_____
When was your last menstrual period?_____
Have you experienced menopause, and if so what age?_____
How many times have you been pregnant? (Include miscarriages)_____
How old were you when your first child was born? _____
Did you breastfeed? _____ How long? _____
Are you pregnant today? (Circle one) Yes No Not sure
Have you ever taken hormone supplements?_____
How many years did you use hormones?_____
How many years since last use of hormones?_____
Have you taken birth control pills?_____
If so, how long?_____
Have you had a hysterectomy? _____When?_____
Have you had your ovaries removed?_____
If so, which one? (Circle one) Right Left Both
Do you feel a new breast lump?_____
Do you have nipple discharge?_____
Do you have breast pain?_____
Do you have a family history of breast cysts? _____

BREAST CANCER HISTORY

**Only answer these questions if you have ever been diagnosed or treated for breast cancer.*
When were you diagnosed with breast cancer? Year: _____Age: _____
Which breast was diagnosed with breast cancer? _____
Did you have surgery for your breast cancer?_____
If yes, lumpectomy or mastectomy?_____
Did you have reconstruction? If yes, circle the option that applies to you:
Saline implants Silicone implants DIEP flap

LAT flap TRAM flap

Did you have radiation for your breast cancer?_____

Did you have chemotherapy for your breast cancer?_____

Did you take medication for your breast cancer?_____

If so, circle the medication that applies to you:

Tamoxifen Femara Aromasin Arimidex Letrozole

Did you have genetic testing?_____

Did you have genetic counseling?_____

BREAST HEALTH & BIOPSY HISTORY

Do you have inverted nipples?_____

If so, for how long, and which breast?

_____

Have you recently had any skin changes to the breast, including dimpling or rashes?_____

_____

Have you ever had a breast MRI?_____

If yes, location and date: _____

Have you ever had a breast biopsy? _____

If yes, how many?_____

Date:_____ Where was this biopsy performed?_____

Result: _____

Date:_____ Where was this biopsy performed?_____

Result: _____

Date:_____ Where was this biopsy performed?_____

Result: _____

Have you ever had a breast biopsy showing atypical cells or LCIS? _____

Do you currently have breast implants?_____

If yes, date and type:_____

Have you ever had breast implants? _____

If yes, date and type:_____

Have you had breast surgery? _____

If yes, date and type of surgery: _____

SURGICAL HISTORY

Please list all surgical procedures that you have had:

DATE	SURGERY	LOCATION	PROBLEMS/COMPLICATIONS?

FAMILY HISTORY

How many brothers do you have? _____ How many sisters do you have?_____

How many daughters do you have? _____How many sons do you have?_____

How many aunts do you have (total/alive and deceased)?

Maternal (mother's side): _____

Paternal (father's side): _____

How many uncles do you have (total/alive and deceased)?

Maternal (mother's side): _____

Paternal (father's side): _____

What is your racial background?_____

Are you of Ashkenazi Jewish ancestry?_____

Have you or your family ever been tested for genetic susceptibility to cancer (genetic testing): _____

FAMILY HISTORY OF CANCER

Indicate in the chart below if any of your family members have been diagnosed with cancer by checking the appropriate box(es) along with the **age of diagnosis.**

	Breast Cancer	Ovarian Cancer	Pancreatic Cancer	Melanoma	Colon Cancer	Stomach Cancer	Other Cancer	Still Living?	
Mother								Yes	No
Maternal Grandmother								Yes	No
Maternal Grandfather								Yes	No
Maternal Aunt								Yes	No
Maternal Uncle								Yes	No
Father								Yes	No
Paternal Grandmother								Yes	No
Paternal Grandfather								Yes	No
Paternal Aunt								Yes	No
Paternal Uncle								Yes	No
Brother								Yes	No
Sister								Yes	No
Son								Yes	No
Daughter								Yes	No

Please add any additional family members diagnosed with a cancer not stated above:

_____

_____

_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms you have experienced in the last 3 months

Breast
Breast pain
Breast lump (past or present)
Breast dimpling
Breast skin changes
Nipple discharge
Nipple inversion

Constitutional
Fevers
Chills
Night sweats
Weight loss
Weight gain
Fatigue
Loss of appetite

Respiratory
Cough
Cough productive of sputum
Coughing up blood
Wheezing
Shortness of breath

Endocrine
Hot flashes
Excessive thirst

Cardiovascular
Chest pain
Palpitations
Leg swelling
Difficulty breathing at rest
Difficulty breathing during activity
Difficulty breathing when lying flat

Gastrointestinal
Nausea
Vomiting
Constipation
Diarrhea
Abdominal pain

Genitourinary
Painful/difficulty urinating
Increased urinating frequency
Polyuria
Urinary incontinence
Vaginal discharge
Postmenopausal vaginal bleeding

Musculoskeletal
Back pain
Muscle pain
Muscle cramps
Muscle weakness
Bone pain
Arthritis

Integumentary
Skin lesions
Rash

Eyes
Visual changes
Dry eyes
Blurred vision

Mouth/Ears/Nose/Throat
Mouth sores
Difficulty swallowing
Hoarse voice
Hearing changes
Difficulty hearing
Neck lumps

Psychiatric
Depression
Anxiety
Agitation

Hematologic/Lymphatic
Enlarged swollen glands
Easy bruising
Difficulty stopping blood flow

Neurologic
Numbness
Weakness
Dizziness
Headaches
Tremor
Lack of coordination
Memory loss

CURRENT MEDICATIONS

List all medications you are currently taking, including over-the-counter medications and supplements.

Name of medication	Strength	Frequency

Do we have your permission to verify your medications? _____Yes _____No

Risk Assessment for Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer* (ER-, PR-, HER2- pathology)			
Y	N	Three or more HBOC-associated cancers at any age in the same person or on the same side of the family HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian, pancreatic, or aggressive prostate cancer in the same person or on the same side of the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____
Patient's Signature Date

FOR OFFICE USE ONLY

- ☐ Candidate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: _____

- ☐ Patient offered genetic testing:
  - ☐ Accepted
  - ☐ Declined

_____
Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.MyriadPro.com/guidelines

MYRIAD®

PARADISE COAST
BREAST SPECIALISTS

PATIENT CONSENT FOR ALTERNATE COMMUNICATION OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Paradise Coast Breast Specialists to use and disclose my protected health information (PHI) in an alternate way so to expedite my treatment, payment, and healthcare operations. I understand that Paradise Coast Breast Specialists does not, in its normal course of business, use these alternate means of communication unless specifically instructed by the patient to do so. I have indicated by providing information in the fields below that I have authorized Paradise Coast Breast Specialists to contact me in alternate ways that are, by their design, not guaranteed to be secure. I will hold my physician and all of Paradise Coast Breast Specialists harmless if, while employing one of these alternate means of communication, the information is inappropriately used by or disclosed to an individual or individuals not authorized by me to have this information. I also assume responsibility for the security of all information that is sent by me to my physician using any alternate communications below.

With my consent, Paradise Coast Breast Specialists may:

Leave detailed messages on my voicemail at this home phone number: _____

Leave detailed messages on my voicemail at this work number: _____

Leave detailed messages on my voicemail at this mobile number: _____

Email me using secure email at this email address: _____

Communicate with or leave detailed messages with a family member/caregiver (include name, relationship to patient, and phone number):

_____

_____

_____

I understand that I may revoke my consent for the use of alternate communications in writing using the revocation notice of this form, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Patient Date of Birth

_____ _____

Print Patient Name Today's date

PARADISE COAST
BREAST SPECIALISTS

Financial Policies and Information

PLEASE READ CAREFULLY

Our commitment is to provide the very best healthcare to you, our patient. Your clear understanding of- and agreement to- our financial policies concerning your medical care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies, or about your responsibilities relating to your insurance coverage, please contact the Practice Manager.

PROFESSIONAL FEES: Our prices are representative of the usual and customary changes for our area. Our fees reflect the Provider's time dedicated to your care. That time includes the review of any prior medical records, diagnostic testing, authorizations and other insurance requirements as well as the coordination of your care with other physicians involved in your health care planning.

INSURNCE PAYMENTS: We participate in assignment of payment with specific insurance plans in the State of Florida. Your insurance coverage is a contract between you and your insurance plan. It is your responsibility to verify and know your insurance benefit coverage including your out of pocket requirements. If your insurance plan is one with which we participate **and** if you have provided valid proof of insurance for that plan, we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a Provider, you must complete all the provided patient paperwork; provide a driver's license or legal identification card; and, provide a current valid insurance card as proof of insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim.

PATIENT PAYMENTS/SELF-PAY BALANCES: your co-payments and deductibles, services not covered by your insurance plan, and self-pay balances are due at the time of your appointment. Your balances are due upon receipt of the Paradise Coast Breast Specialists statement unless you have made other arrangements prior to the service being rendered. You may pay by check or credit card. We accept Visa, MasterCard, Discover and American Express and encourage you to utilize the "Credit Card on File" program for easy and convenient balance resolution. After 90 days of non-payment, your account may be turned over to a collection agency.

APPOINTMENTS: Please understand that your appointment is time that has been reserved for your health care needs. If you are running late, please call us as soon as possible at (239) 734-3533; if you need to cancel your office and/or procedure appointment, **please call us 24 hours in advance** at the phone number above as a courtesy to the Provider.

NON-COVERED SERVICES: Some services you receive may be non-covered or may be considered not necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

MEDICARE BENEFICIARIES: Medicare will sometimes limit coverage of certain goods or services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potential for denial of your claim for either of these reasons, in accordance with Medicare requirements, you will be asked to complete an Advanced Beneficiary Notification Form (ABN) which will provide you the opportunity to be given the expected cost to you for the services—prior to services being rendered. You will be able to elect to receive the services and be responsible for the cost Medicare assigns, or, elect to decline the services.

COLLECTION AGENCIES: After 90 days of non-payment for services rendered, your account may be turned over to a collection agency.

BOUNCED CHECKS: A $50 charge will be applied for each check returned by your bank. If you have had more than one bounced check, your Provider may elect not to accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUTES AN AGREEMENT TO THIS POLICY.

I have read and agree to the above Financial Policies and Information. I hereby assign all medical and/or surgical benefits to which I am entitled through my insurance—government or private—to Paradise Coast Breast Specialists. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as the original.

Printed name of Patient: _____ Patient's DOB:_____

_____ _____ _____

Signature of Person Responsible for the Account | Printed Name of Person Responsible for the Account | Date