

# ATLANTA *Breast Care*

275 Collier Road NW, Suite 470, Atlanta, GA 30309

Phone: 404-351-1002 | Fax: 404-350-8290

[www.atlantabreastcare.com](http://www.atlantabreastcare.com)

[info@atlantabreastcare.com](mailto:info@atlantabreastcare.com)

Please complete these forms online or by hand, then print and bring them to your appointment. You may also scan and email them to

**info@atlantabreastcare.com** or

fax to **404-350-8290**. Please

include a **copy of your insurance card**

(front and back) with your completed

New Patient paperwork.

We look forward to seeing you in our office.

*Thank you!*

William A. Barber, MD, FACS  
Erin B. Bowman, MD, FACS  
Amanda J. Morehouse, MD, FACS  
Lucy B. Wallace, MD, FACS

Anna Deriso, RNC, WHNP, MSN  
Kristy Donaldson, PA-C  
Lauren McDermott, PA-C  
Jennifer Munn, RN, CBCN



275 Collier Road NW, Suite 470, Atlanta, GA 30309  
 Phone: 404-351-1002 | Fax: 404-350-8290  
 www.atlantabreastcare.com  
 info@atlantabreastcare.com

William A. Barber, MD, FACS  
 Erin B. Bowman, MD, FACS  
 Amanda J. Morehouse, MD, FACS  
 Lucy B. Wallace, MD, FACS

Anna Deriso, RNC, WHNP, MSN  
 Kristy Donaldson, PA-C  
 Lauren McDermott, PA-C  
 Jennifer Munn, RN, CBCN

# MALE NEW PATIENT

Name \_\_\_\_\_ Today's date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Referring Physician: \_\_\_\_\_

List of Current Physicians: \_\_\_\_\_

Have you or any family member been tested for the "breast cancer gene" (BRCA 1 or 2)?  Yes  No  
 Results if known: \_\_\_\_\_ When: \_\_\_\_\_

Are you of Ashkenazi Jewish decent?  Yes  No

Have you ever had a breast biopsy/aspiration/surgery?  Yes  No  
 Results if known: \_\_\_\_\_ When: \_\_\_\_\_

## SOCIAL HISTORY

Average caffeine intake / **quantity**:  Daily \_\_\_\_\_  Weekly \_\_\_\_\_  Rarely \_\_\_\_\_  None

Average alcohol intake / **quantity**:  Daily \_\_\_\_\_  Weekly \_\_\_\_\_  Rarely \_\_\_\_\_  None

Do you smoke tobacco?  Yes, currently  Yes, previously  No

If yes, how much \_\_\_\_\_ for how long \_\_\_\_\_

If applicable, when did you quit? \_\_\_\_\_

Do you smoke marijuana?  Yes, currently  Yes, previously  No

Do you use illicit substances?  Yes, currently  Yes, previously  No

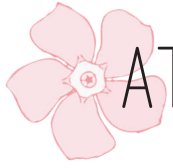
If yes, what type? \_\_\_\_\_

Do you use performance enhancing supplements/vitamins?  No  Yes, currently  Yes, previously

If yes, what type? \_\_\_\_\_

## FAMILY CANCER HISTORY > Please specify the type of cancer if "other" is checked.

Cancer Type	(circle one)	Relation	Age at diagnosis	Living	Age at death
<input type="checkbox"/> Breast <input type="checkbox"/> Other _____	maternal/paternal	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Breast <input type="checkbox"/> Other _____	maternal/paternal	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Breast <input type="checkbox"/> Other _____	maternal/paternal	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____



Name \_\_\_\_\_ Today's date \_\_\_\_\_

If you have ANY of the following medical issues please check (or complete where applicable):

<input type="checkbox"/> Cancer	Type	Year Diagnosed
<input type="checkbox"/> Autoimmune Disease	Type	Year Diagnosed
<input type="checkbox"/> Bleeding/Clotting Disorder	Type	Year Diagnosed
<input type="checkbox"/> Skin Problems	Type	Year Diagnosed
<input type="checkbox"/> Thyroid Disease	Type	Year Diagnosed
<input type="checkbox"/> Anemia	<input type="checkbox"/> GERD/Reflux	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Arthritis/Osteoarthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Migraines
<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> PCOS
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Depression	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Irregular Heart Rate/Rhythm	
<input type="checkbox"/> Sleep Apnea: (circle one) CPAP or APAP		<input type="checkbox"/> Diabetes: (circle one) Type I or Type II

Please list any surgeries (ie: oral, orthopedic, etc.) and **include month/year of surgery**:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have an allergy to any medications?  Yes  No

If yes, please list the drug and the reaction: \_\_\_\_\_

### Current medications/vitamins:

Name	Dose	Frequency
_____		
_____		
_____		
_____		
_____		

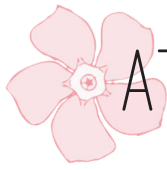
### Other relevant info:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# ATLANTA Breast Care

275 Collier Road NW, Suite 470, Atlanta, GA 30309  
Phone: 404-351-1002 | Fax: 404-350-8290  
www.atlantabreastcare.com  
info@atlantabreastcare.com

William A. Barber, MD, FACS  
Erin B. Bowman, MD, FACS  
Amanda J. Morehouse, MD, FACS  
Lucy B. Wallace, MD, FACS

Anna Deriso, RNC, WHNP, MSN  
Kristy Donaldson, PA-C  
Lauren McDermott, PA-C  
Jennifer Munn, RN, CBCN

---

First Name	MI	Last Name	Preferred Name
_____	_____	_____	_____
SSN	Birth Date	Email Address ( <i>required for Portal Access</i> )	
_____	_____	_____	

---

Address \_\_\_\_\_

---

City	State	Zip
_____	_____	_____

PLEASE CHECK YOUR PREFERRED CONTACT NUMBER BELOW (Check ONE only)

<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Cell
-------------------------------	-------------------------------	-------------------------------

Marital Status: S  M  D  W  Significant other's name: \_\_\_\_\_

---

Emergency Contact	Relation	Contact Number
_____	_____	_____

## INSURANCE INFORMATION

Primary Insurance Co. \_\_\_\_\_ Group Number \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ ID# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Group Number \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ ID# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

---

Responsible Party if other than patient	Relation	Contact Number
_____	_____	_____

I hereby authorize Atlanta Breast Care to bill my insurance carrier for any services rendered by any agents of the practice. With this authorization I assign any and all benefits payable for services rendered by Atlanta Breast Care or agents of the practice. I understand that I am responsible for any amount not covered by my insurance plan.

I hereby authorize the release of any and all medical information necessary to the treatment I receive while under the care of Atlanta Breast Care. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports to Atlanta Breast Care. A copy of this authorization shall be valid as the original.

---

Patient or Guardian Signature	Date
_____	_____

**INSURANCE**

It is the patient's responsibility to provide the most current insurance information available. In the event that we are provided with incorrect insurance information, the patient will be responsible for the balance. Any deductible, co-pay or co-insurance required by your insurance will be collected at the time of service. To assist you in filing your own insurance claim, we will provide you with an itemized statement.

We will submit claims to your insurance company on your behalf. You are responsible to ensure that we have a current referral on file, if required by your insurance company. While we have participation agreements with most carriers, you are responsible to know its limitations and reimbursement levels. If we do not participate with your insurance carrier we require payment at the time of service for office visits and procedures.

**NO SHOW POLICY**

A "no-show" is someone who misses an appointment without cancelling 24 hours in advance. We reserve the right to bill you a \$50 no-show fee.

**SURGERY**

Any deductible, co-insurance, or out of pocket expenses should be paid in full prior to surgery.

**FEES FOR NON-PHYSICIAN SERVICES**

Returned check fees are \$40. A billing fee of \$2.50 will be added to all account balances carried from one month to the next. The fee for completion of forms including disability forms, cancer policy claim forms, letters for cancellations of airline reservations, excuses from services such as jury duty, etc. is \$25. Additional form completions are \$15. We follow the State of Georgia's fee schedule for copies of medical records. Atlanta Breast Care reserves the right to charge a minimum fee of \$15 for a request for medical records.

**ACCOUNT BALANCES**

Payments can be made with cash, check, credit card, or money order. Account balances will be kept open for no longer than 120 days. After 120 days, unpaid balances including incurred interest, will be turned over to an outside collection company, the undersigned is required to pay all collection fees, including, but not limited to legal/attorney's fees.

**QUESTIONS?**

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with our business office staff.

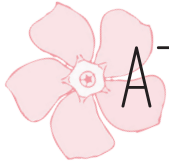
I have read and understand my financial responsibilities under this policy.

---

Patient or Guardian Signature

---

Date



Written Acknowledgement of Receipt of Notice of Privacy Practices

Notice of Privacy Practices can be found on our website or provided for your review in our office.

Please select ONE of the following:

I, \_\_\_\_\_, have reviewed a copy of Atlanta Breast Care's Notice of Privacy Practices.
Patient Name

I, \_\_\_\_\_, decline to review a copy of Atlanta Breast Care's Notice of Privacy Practices.
Patient Name

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

RELEASE OF MEDICAL INFORMATION

I authorize the release of medical information to the following:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please PRINT name

\_\_\_\_\_  
Birth Date

Please inform us of anyone you do NOT want to receive any information regarding your medical care:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name