Astera BREAST CARE

At The Breast Center
Saint Peter's University Hospital

New Patient Packet

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Saint Peter's University Hospital

New Patient Medical History

Patient Name:_____Today's Date: _____

DOB: _____ / _____ / _____ □ Male □ Female SSN: _____

Address: _____

_____

Primary Phone:_____ ☐ Home ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Cell

May we leave a message on your answering machine / voicemail? ☐ Yes ☐ No

Email Address:_____May we email you? ☐ Yes ☐ No

Emergency Contact Name: _____

Relationship:_____Phone:( )_____

Power of Attorney (if applicable):_____ Relation to you:_____

Living Will: ☐ Yes* ☐ No **Please provide a copy for your records*

Preferred Language: _____

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American ☐ Asian/Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Are you: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

(Former) Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner

☐ Lives alone ☐ Lives with family

Children ☐ Yes ☐ No

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Other Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Patient Name: _____

Surgical History: Please list all surgeries you have had with approximate date:

_____

_____

_____

_____

_____

Implanted Medical Devices (Check all that apply):

☐ Pacemaker ☐ Defibrillator ☐ Infusion Port ☐ Insulin Pump ☐ Dialysis Access Port ☐ VP Shunt

Social History

Tobacco User:

☐ Never Smoked

☐ Quit Smoking When did you quit? _____How many years did you smoke? _____ Yr(s)

☐ Currently smoke: What age did you start? _____How many packs? _____/day

Alcohol User: Present or Past

☐ Non-Drinker

☐ Drinker ☐ Current ☐ Past How many drinks per day? _____

Health Maintenance: _____

Sigmoidoscopy / Colonoscopy: ☐ Yes ☐ No Date:_____Influenza (Flu) Shot: ☐ Yes ☐ No Date: _____

Mammogram: ☐ Yes ☐ No Date: _____ Pneumococcal Shot: ☐ Yes ☐ No Date: _____

Bone Density: ☐ Yes ☐ No Date: _____ COVID-19 Shot: ☐ Yes ☐ No Date: _____

Pap Smear: ☐ Yes ☐ No Date: _____

Females:

Age of 1st Pregnancy:_____ # of Pregnancies: _____ # of Deliveries: _____ Did you breastfeed? ☐ Yes ☐ No

First day of last menstrual period: _____ Age of first period: _____ Age of menopause: _____

History of Hormone Replacement Therapy? ☐ Yes ☐ No If Yes, How many years?: _____

History of Oral Contraceptive use? Yes No

Other Medical History not listed above:

_____

_____

_____

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Patient Name: _____

Family History

	Age	Alive/Deceased	Health Status Medical History
Mother	_____	_____	_____
Father	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Children	_____	_____	_____

Family History of Cancer: Indicate any family members with cancer, blood disease or other disease

	Age	Alive/Deceased	Type of Cancer
Mother	_____	_____	_____
Father	_____	_____	_____
Daughter	_____	_____	_____
Son	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____

			Age diagnosed	Type of Cancer
Aunt	☐ Maternal	☐Paternal	_____	_____
Uncle	☐ Maternal	☐ Paternal	_____	_____
Grandmother	☐ Maternal	☐ Paternal	_____	_____
Grandfather	☐ Maternal	☐ Paternal	_____	_____
Cousin / 1st – 2nd	☐ Maternal	☐Paternal	_____	_____

Have you had genetic testing done? ☐ Yes ☐ No Have any of your family members had genetic testing? ☐ Yes ☐ No

Medications: Please list any medications you are taking at this time **(including hormones and vitamins)**

Medication	**Dose**	**How often**	**How taken (oral/injection/topical)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

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Patient Name: _____ **Date:**_____

Do you have a latex allergy? □ No □ Yes Do you have an allergy to IV contrast? □ No □ Yes

Do you have any medication allergies? □ No □ Yes - please list below:

Medication Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

Pain Rating - If you have pain, where is it located? _____

0 1 2 3 4 **5** 6 7 8 9 **10**

NO PAIN **MODERATE PAIN** **WORST POSSIBLE PAIN**

Reason for this Visit: _____

_____

_____

Review of Systems: *Please check any symptoms you are currently experiencing:*

Constitutional
□ Fatigue
□ Fever
□ Chills
□ Night sweats
□ Difficulty Sleeping
□ Weight loss >10 lbs.
□ Weight gain >10 lbs.

Head and Neck
□ Hearing changes
□ Eye pain
□ Ear pain
□ Oral sores
□ Dry Mouth
□ Change in voice
□ Sore throat
□ Difficulty swallowing
□ Jaw pain

Skin
□ Itching
□ Rashes
□ New or changed mole
□ Unhealed sores
□ Nail changes
□ Change in skin color

Cardiovascular
□ Chest pain
□ Palpitations
□ Dizziness or fainting
□ Leg swelling

Respiratory
□ Shortness of breath
□ Wheezing
□ Cough
□ Coughing up blood

Gastrointestinal
□ Loss of appetite
□ Indigestion/heartburn
□ Bloating
□ Abdominal pain
□ Nausea/vomiting
□ Diarrhea
□ Constipation
□ Rectal bleeding
□ Incontinence

Neurological
□ Headaches
□ Visual changes
□ Dizziness
□ Memory loss
□ Confusion
□ Numbness/tingling
□ Muscle weakness
□ Unsteady gait

Lymphatics
□ Easy bruising
□ Swollen glands
□ Swelling of arm/leg

Endocrine
□ Increased thirst
□ Increased urination
□ Hair changes
□ Cold intolerance

Psychiatric
□ Anxiety
□ Depression

Musculoskeletal
□ Joint swelling
□ Muscle or joint pains
□ Back pain
□ Bone pain

Genitourinary
□ Frequent urination
□ Urinary urgency
□ Urinary burning
□ Blood in urine
□ Incontinence

GU - Male
□ Impotence
□ Testicular pain
□ Penile pain

Breast
□ Breast Mass
□ Breast Pain
□ Nipple Discharge

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Primary Insurance Carrier: _____ Policy ID#: _____

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does the plan have prescription coverage? □ Yes □ No

Secondary Insurance Carrier: _____ Policy ID#: _____

Name of secondary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does the plan have prescription coverage? □ Yes □ No

How did you learn about Astera?

□ Physician Referral □ Family / Friends □ Insurer

□ Advertisement □ Internet Search □ Astera Website

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____Date: _____

Print Name: _____

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Request For Release Of Records

I, _____, request a copy of my complete medical record from the office of:_____

Name and Address of Practitioner:

_____

To be sent to Astera Cancer Care:

_____

Address, City State Zip Code:

_____

Fax/Telephone Number:

_____

_____ I give permission to Fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

Provide office fax number: _____

It is my understanding that by signing this authorization for release of my records, I am giving permission for Astera Cancer Care to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire 1 year after the date below or sooner at my election.

_____ _____

Print Patient Name Date

_____ _____

Signature Patient, Parent, or Legal Guardian/Representative Date

_____ _____

Witness Date

Astera Cancer Care is committed to protecting the privacy of individual health information in compliance with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (both Acts together, "HIPAA") and the regulations promulgated there under. These policies and procedures apply to protected health information ("PHI") created, received, maintained or transmitted by Astera Cancer Care after April 1, 2021.

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USE OR DISCLOSURE AUTHORIZATION FORM

Name of Individual Authorizing Use or Disclosure **Telephone Number**

I hereby authorize the use and/or disclosure of my Protected Health Information by Astera Cancer Care as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health care provider or health plan, the released information may be re-disclosed and may no longer be protected by the federal privacy laws and regulations.

1. The following health information will be disclosed (please check):
   - □ Cardiac studies
   - □ Complete record
   - □ Consultations (including psychiatric evaluations)
   - □ Discharge Summary
   - □ Emergency Department Record
   - □ History & Physical Examination
   - □ Interdisciplinary Records (Progress Notes)
   - □ Laboratory Reports (including drug screens)
   - □ Medication Records
   - □ Nursing Notes
   - □ Operative and/or Procedure reports
   - □ Physician Orders
   - □ Radiology or Imaging Reports
   - □ All of the above
   - □ Other: (fill below)

_____

_____

2. Person or organization authorized to receive the health information (for example: names of family, caregivers and friends, health insurance, health plan, other providers administering care coordination services):

_____

_____

_____

3. Description of each purpose for which the health information will be used/disclosed (Note: if the individual elects not to provide a reason, insert "At the request of the individual"):

_____

_____

_____

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USE OR DISCLOSURE AUTHORIZATION FORM (continued)

4. I understand that the person or organization that I am authorizing to use or disclose the information may receive compensation in exchange for the health information described above.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits. *
6. I understand that I may revoke this authorization at any time by providing written notice to Astera Cancer Care, J-2 Brier Hill Court, East Brunswick, NJ 08816.
7. I understand that my revocation of this authorization will not affect any actions already taken in reliance on this authorization or certain actions listed in the Astera Cancer Care Notice of Privacy Practices.
8. I understand that I may inspect or copy any information to be used or disclosed under this authorization.
9. Unless otherwise revoked in writing, this authorization will expire _____ days from the date signed below. If this date is left blank, the authorization will automatically expire one (1) year from the date I sign below.
10. Submitted to Astera Cancer Care.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative
(Print)

_____

Description of Personal Representative's Authority

*A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(4)(ii)(A&B)).

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BILLING POLICY PATIENT AGREEMENT

I acknowledge that I am responsible for payment of the fee for medical services rendered by Astera Cancer Care, regardless of any reimbursement to which I may be entitled by reason of insurance or legal claims. I am aware that it is solely my responsibility to know, in advance of the service, the benefits and guidelines of my individual insurance coverage; to obtain all necessary insurance referral forms and/or pre-certification; and to confirm plan in which Astera Cancer Care, is a participating provider, the payment guidelines of my plan will prevail. I authorize Astera Cancer Care to prepare and submit the appropriate claim forms to my primary and secondary (if any) insurance carrier (s). I hereby assign all insurance benefits relating to these medical services to Astera Cancer Care and authorize the release of all information necessary to effect payment of those benefits. Even though payment may be sent directly to Astera Cancer Care, I understand that I am still responsible for any balance remaining and will pay any amount not covered by my insurance.I understand that if I fail to keep any financial agreement, I make with Astera Cancer Care and my account must be sent to a collection agency, I will be responsible for all collections cost and legal fees.

_____ _____ / _____ / _____
Patient's Printed Name **Patient's Date of Birth**

_____ _____ / _____ / _____
Patient or Patient's Representative Signature **Today's Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below, I am acknowledging I have received a copy of the Astera Notice of Privacy Practices concerning the uses and disclosures of my Protected Healthcare Information in accordance with the HIPAA Privacy and Security Rules.

_____ _____ / _____ / _____
Patient's Printed Name **Patient's Date of Birth**

_____ _____ / _____ / _____
Patient or Patient's Representative Signature **Today's Date**

Rev: 1-25-2022