# *MICHAEL D. GRANT, M.D., P.A.*

| NAME OF REFERRING PHYSICIAN: | | | | PHONE: |
|---|---|---|---|---|

| PATIENT LAST NAME | FIRST NAME | M.I. | NAME YOU PREFER TO BE CALLED |
|---|---|---|---|

| STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|

| SOCIAL SECURITY NUMBER | DRIVERS LICENSE NUMBER |
|---|---|

| HOME PHONE | BIRTHDATE | AGE | SEX M F | OCCUPATION |
|---|---|---|---|---|

| WORK PHONE | EMPLOYER NAME |
|---|---|

| EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|

MARITAL STATUS:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

| NAME OF SPOUSE (or responsible party if no spouse) | RELATIONSHIP TO PATIENT |
|---|---|
| SPOUSE'S EMPLOYER NAME & ADDRESS | PHONE NUMBER |

| PRIMARY INSURANCE COMPANY NAME | CLAIMS MAILING ADDRESS | | |
|---|---|---|---|
| POLICY HOLDER NAME | EMPLOYEE I.D. NUMBER | GROUP NO. OR NAME | POLICY HOLDER BIRTHDATE & SEX M F |
| SECONDARY INSURANCE COMPANY NAME | CLAIMS MAILING ADDRESS | | |
| POLICY HOLDER NAME | EMPLOYEE I.D. NUMBER | GROUP NO. OR NAME | POLICY HOLDER BIRTHDATE & SEX M F |

| NEAREST RELATIVE or EMERGENCY CONTACT (Not at your address) | RELATIONSHIP? | AREA CODE & PHONE NUMBER |
|---|---|---|

**I request that payment of authorized insurance or Medicare benefits be made on my behalf for any services furnished to me by or in Michael D. Grant, M.D., P.A. I authorize any holder of medical or other information about me to release to the insurance companies shown above or to Health Care Financing Administration or their agents any information needed to determine these benefits or benefits for related services. I am willing that a photocopy of this authorization be accepted with same authority as the original.**

**Date:________________ Signature: ________________________________________**

**PLEASE NOTE: It is our policy to request payment for routine and/or noncovered services at the time they are rendered.**

# *MICHAEL D. GRANT, M.D., P.A*
# *PATIENT INFORMATION QUESTIONNAIRE*

**PLEASE FILL OUT ALL INFORMATION:**

**NAME:** ____________________________
**BIRTHDATE:** _______________________
**HOME PHONE:** _____________________
**WORK PHONE:** _____________________

**WHO REFERRED YOU TO DR. GRANT?**
__________________________________

**NAME OF FAMILY PHYSICIAN/INTERNIST**
__________________________________

**NAME OF OB/GYN**
__________________________________

**WOULD YOU LIKE PROGRESS LETTERS SENT TO YOUR PHYSICIANS? YES NO**

**FOR OFFICE USE ONLY**

**Med Onc.**________________________
**Rad Onc.**________________________
**Plastics** ________________________

**♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦Proto col:**______________________
**Surgery:** _______________________
**Path:** _______________________
_______________________
_______________________
_______________________
**Nodes:** _______________________
**ERA:** _______________________
**PRA:** _______________________
**Mib-1/Ki-67:** ___________________
**HER 2/neu:** _____________________

**DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? YES NO**
**(PLEASE CIRCLE YOUR RESPONSE BELOW AND GIVE APPROXIMATE AGE OF DIAGNOSIS)**

**Self**________ **Grandmother**________ **Mother**________

**Aunt**_______ **Daughter** __________ **Sister** ________

**CAFFEINE HISTORY: (HOW MANY DAILY SERVINGS OF EACH DO YOU CONSUME?)**

**Coffee** ________ **Tea** ________ **Colas** ________ **Chocolate** ________

**GYNECOLOGICAL HISTORY:**
**Gravid (How many times have you been pregnant?)** ________
**Parity (How many children have you delivered?)** ________
**Menarche (Age of first menstrual period)** ________

**HORMONE HISTORY:**
**Have you ever taken birth control pills? If so, how long and at what ages?**

**Have you ever taken supplemental hormones (estrogen or progesterone)? What kinds? How long? What ages?**

**GYNECOLOGICAL SURGERY:**
**Have you had a hysterectomy (removal of the uterus)? YES NO**

**Have you had an oophorectomy (removal of the ovaries)? YES NO**

*MICHAEL D. GRANT, M.D., P.A.*

# *MEDICAL HISTORY QUESTIONNAIRE*

**MEDICAL ILLNESSES:** **HAVE YOU HAD OR DO YOU STILL HAVE?**
**Please check your response:**

- ☐ **Bronchitis**
- ☐ **Chronic Cough**
- ☐ **Asthma**
- ☐ **Pneumonia**
- ☐ **TB**
- ☐ **Emphysema**
- ☐ **Other Lung Disease**
- ☐ **High Blood Pressure**
- ☐ **Heart Attack**
- ☐ **Chest Pain/Angina**
- ☐ **Rheumatic Fever**
- ☐ **Mitral Valve Prolapse**
- ☐ **Kidney Failure**
- ☐ **Anemia**
- ☐ **Bleeding Problems**
- ☐ **Sickle Cell Disease**
- ☐ **Hepatitis**
- ☐ **Liver Trouble**
- ☐ **Stroke**
- ☐ **Epilepsy/Convulsions**
- ☐ **Thyroid Disease**
- ☐ **Diabetes**
- ☐ **Low Blood Sugar**
- ☐ **HIV**
- ☐ **Cancer**
- ☐ **Other Illnesses**

**SURGICAL HISTORY:** **Please list all major surgeries (and breast procedures) that you have had and include approximate dates of the procedures.**

**MEDICATIONS:** **Please list all medications that you take—both prescription and nonprescription drugs.**

**ALLERGIES:** **Please list any serious side effects to any medications.**

**DO YOU HAVE A HISTORY OF CIGARETTE SMOKING? YES NO**
**IF SO, HOW MANY PACKS PER DAY AND FOR HOW MANY YEARS?**

**DO YOU DRINK ALCOHOL? YES NO**

**OCCASIONALLY MODERATELY EXCESSIVELY**

# Consent for Use and Disclosure of Information

I have reviewed the "Notice of Privacy Practices" of Dr. Michael Grant and have had all questions answered by this office. I also consent to the use or disclosure of my protected health information for the following purposes:

- **TREATMENT**
  It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.
- **PAYMENT**
  Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for your billing personnel including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.
- **HEALTHCARE OPERATIONS**
  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

______________________________ ____________________

**Patient Name (Printed)** **Date**

X______________________________

**Patient Signature (or Guardian)**

My signature below indicates that I have received a copy of this "Notice of Privacy Practices" and that if I have any questions regarding this notice that I can discuss with the designated Privacy Officer.

X______________________________ ____________________

**Patient Signature** **Date**

# MICHAEL D. GRANT, M.D., P.A.
# NOTICE OF PRIVACY PRACTICES

**This notice describes how your personal healthcare information may be disclosed or used by this office. Please read this notice carefully. If you have any questions, please contact our Privacy Officer. After reviewing this document, you will be asked to sign that you have received this notice.**

**This office is required to abide by the terms of this Notice of Privacy Practices. The terms may change at any time and the revised notice will apply to all protected health information maintained at that time. You may request a revised copy of this notice by calling our office.**

This office has taken reasonable steps to safeguard the privacy and confidentiality of your Protected Health Information (PHI). The staff of this office will only use your health information for the intended patient care purpose. Conversations among staff members that reference your information will be conducted in a confidential and professional manner.

## 1. Uses and Disclosures of Protected Health information for TPO

This office will need to access your protected health information for purposes of treatment, payment and operations (TPO) in accordance with State and federal Law.

> **USING & DISCLOSING INFORMATION FOR TREATMENT PURPOSES**
To maintain high quality healthcare, it will be necessary to share protected health information with all members of your treatment team. This can include employees in this office as well as other providers.

> **USING & DISCLOSING INFORMATION FOR PAYMENT PURPOSES**
Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for our internal billing personnel to have access to protected health information to carry out their job functions.

> **USING & DISCLOSING INFORMATION FOR OPERATIONS PURPOSES**
Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, and compliance with all federal and state laws.

## 2. Specific Authorization required for other uses and disclosures

Other uses and disclosures of your protected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form. Some examples include but are not limited to: some marketing activities, the use or disclosure of psychotherapy records in our possession and in some instances for research purposes.

**3. Other uses and disclosures without your authorization**

The following are situations where this office may use or disclose your protected health information without your consent or authorization:

- Uses and disclosures of protected health information (PHI) as required by law, court orders, a legal process, or government agencies.

- Uses and disclosures of PHI for matters of public health for the purpose of controlling disease as dictated by law.

- Uses and disclosures to government oversight agencies for the purpose of health and privacy audits or investigations.

- Uses and disclosures may be made to public health authorities in situations of suspected abuse or neglect.

- Uses and disclosures to Institutional Review Boards for the purpose of medical research.

**4. Patient Privacy Rights effective April 14. 2003**

- In general you will have the right to review and copy your protected health information as well as amend your record. Some exceptions include, but are not limited to: psychotherapy notes, information compiled fore use in a civil, criminal, or administrative proceeding.

- You have the right to request a restriction of the disclosure of your protected health information for treatment, payment, or operations. This office is not required to agree to the request, but will do so at our discretion.

- You have the right to request to receive confidential communications from us by alternative means or to an alternative location. We will make every effort to honor reasonable requests.

- You have the right to request an accounting of the disclosures made of your protected health information by this office (after April 14, 2003). This only applies to disclosures made for purposes other than treatment, payment, or operations.

**5. Privacy Officer & Complaints**

Should you have any concerns you may contact our Privacy Officer who is responsible for the privacy and confidentiality of your information in accordance with state and federal law. Any complaints or issues you have regarding the privacy or confidentiality of your information should be directed to the privacy officer.