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

PATIENT FIRST NAME	M.I.	LAST NAME	NAME YOU PREFERRED TO BE CALLED

SEX M F	AGE	MARITAL STATUS: □ MARRIED □ SINGLE □ DIVORCED □ WIDOWED □ SEPARATED

DATE OF BIRTH / /	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE#:	CELL #:	WORK PHONE#:

EMAIL ADDRESS	EMPLOYER / OCCUPATION

NAME OF REFERRING PHYSICIAN:

NAME OF PRIMARY CARE PHYSICIAN:

PRIMARY INSURANCE COMPANY NAME		CLAIMS MAILING ADDRESS		
I.D. NUMBER		GROUP NUMBER	SPECIALIST COPAY $	
POLICY HOLDER NAME	EMPLOYER	RELATIONSHIP TO INSURED	SEX M F	POLICY HOLDER BIRTHDATE / /

SECONDARY INSURANCE COMPANY NAME		CLAIMS MAILING ADDRESS		
I.D. NUMBER		GROUP NUMBER	SPECIALIST COPAY $	
POLICY HOLDER NAME	EMPLOYER	RELATIONSHIP TO INSURED	SEX M F	POLICY HOLDER BIRTHDATE / /

I request that payment of authorized insurance or Medicare benefits be made on my behalf for any services furnished to me by or in the office of 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 non-covered services at the time they are rendered.

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

NAME: _____

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER?

☐ **NO**

☐ **YES:** **Please circle your response below and give approximate age of breast cancer diagnosis.**

Self _____ **Grandmother** _____ **Mother** _____

Aunt _____ **Daughter** _____ **Sister** _____

DO YOU HAVE A FAMILY HISTORY OF OVARIAN CANCER?

☐ **NO**

☐ **YES:** **Which relative(s) had ovarian cancer and give approximate age if the diagnosis.**

DO OTHER CANCERS TEND TO OCCUR IN YOUR FAMILY (colon, prostate, gastric, melanoma etc.)?

☐ **NO**

☐ **YES:** **Which relative(s) had cancer and what type of cancer did they have?**

<u>GYNECOLOGICAL HISTORY</u>:

Gravid (How many times have you been pregnant?): _____

Parity (How many children have you delivered?): _____

Menarche (Age of first menstrual period): _____

Have you gone through menopause yet? ☐ **NO** ☐ **YES** ☐ **UNKNOWN**

Have you had a hysterectomy (removal of the uterus)? ☐ **NO** ☐ **YES**

Have you had on oophorectomy (removal of ovaries)? ☐ **NO** ☐ **YES**

<u>HORMONE HISTORY</u>:

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?

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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

Patient Acknowledgment for Receipt of Notice of Privacy Practices Michael D. Grant M.D., P.A.

I have been presented with a copy of Michael D. Grant M.D., P.A. Notice of Privacy Practices, detailing how my *protected health information* may be used and disclosed as permitted under Federal and State law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Michael D. Grant M.D., P.A. must have my consent. Therefore, I authorize Michael D. Grant M.D., P.A. to **disclose my PHI, as described on this form, to any of the recipients listed below:**

Physician Full Name: _____

Physician Full Name: _____

Family Member/Friend:	Family Member/Friend:	Family Member/Friend:
_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship
_____	_____	_____
Phone Number	Phone Number	Phone Number

PATIENT CONTACT INFORMATION

I authorize Michael D. Grant M.D., P.A. to contact me at the following numbers with results or questions:

HOME# _____ May we leave results on answering machine / voicemail? **YES** **NO**

WORK# _____ May we leave results on answering machine / voicemail? **YES** **NO**

CELL# _____ May we leave results on answering machine / voicemail? **YES** **NO**

My signature below indicates that 1. I have received and reviewed a copy of the Michael D. Grant M.D., P.A. Notice of Privacy Practices, and 2. If I have any questions regarding this Notice, I can discuss it with the office's designated Privacy Officer. I understand that my treatment may be conditioned upon my consent. Further, my consent is given freely and I understand that I can revoke this consent at any time in writing as defined in the Notice.

X _____ **DATE:** _____

Patient / Legal Representative Signature