Center for Breast Care
AND OUTPATIENT SURGERY

Dear Patient,

In the near future, you are scheduled to see Dr. Ronald Yarrington at the Center for Breast Care and Outpatient Surgery. Our office is located at 5327 Commercial Way, Suite D-119, in the Park Place Office Complex. ***You will need to bring your photo ID, insurance card, any films or studies you may have, this paperwork filled out, and your co-payment.*** Please be advised that during the initial consultation no surgery will be performed.

Please remember if your insurance requires authorization, it is your responsibility to have it forwarded to our office as soon as possible. Our fax number is 352-596-6559. Failure to have authorization will result in either rescheduling the appointment or treating you as a self pay and payment will need to be made at the time of service.

Directions:

We are located approximately one half mile north of the Home Depot and one mile south of Weeki Wachee Mermaid attraction. If you are going north on Hwy 19 turn left onto River Country Drive and make an immediate left onto the frontage road. You will see a brick wall with a sign that reads "Park Place Office Complex". Turn right into the complex and right again into the parking lot. We are the second office, Suite D-119.

Appointment day and time:______________________________

Ronald M. Yarrington, M.D., F.A.C.S.
Board Certified in General Surgery
Member, American Society of Breast Surgeons

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PATIENT REGISTRATION FORM

Patient Information (please fill out completely)

Date: ____________________

Last Name: ____________________ First Name: ____________________ Middle Initial: ______

Street Address: ____

City: ____________________ State: __________ Zip Code: __________

Home Telephone: ____________________ Date of Birth: ____________________ Sex: ☐ M ☐ F

Social Security Number: ____________________ Marital Status: ☐ Single ☐ Married ☐ Other

Employer: ____________________ Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Work Telephone: ____________________ Occupation: ____________________

Primary Physician (PCP): ____________________ Office Telephone: ____________________
First Last

Who referred you? ____________________ Telephone: ____________________

In case of Emergency Notify: ____________________ Telephone: ____________________

Preferred Pharmacy: ____________________ Telephone: ____________________

Responsible Party

Name of person responsible for payment: ____________________ Relationship: __________

Address: ____________________ City: ____________________

State: __________ Zip Code: __________ Employer: ____________________

Employer Address: ____________________ City: ____________________

State: __________ Zip Code: __________ Work Telephone: ____________________

Primary Insurance

Insurance Name: ____________________ Insurance Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Policy Number: __________ Plan Name: __________ Plan Number: __________

Primary Holder Name: __________ Relationship: __________ Date of Birth: __________

Secondary Insurance

Insurance Name: ____________________ Insurance Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Policy Number: __________ Plan Name: __________ Plan Number: __________

Primary Holder Name: __________ Relationship: __________ Date of Birth: __________

Please present insurance cards and a photo identification (driver's license) to the receptionist so copies may be made. Do we have your permision to:

- Leave a message on your answering machine at home? ☐ yes ☐ no
- Leave a message at your place of employment? ☐ yes ☐ no
- Discuss your medical condition with any member of your household? ☐ yes ☐ no

If yes, whom: ____________________ Relationship: ____________________

______________________________ Patient Signature

______________ Date

HISTORY

NAME______________________________ AGE__________ TODAY'S DATE______________

BIRTH DATE______________________________ SOCIAL SECURITY #______________________

PRIMARY CARE AND/OR FRIEND REFERRING YOU TO US______________________ LAST PHYSICAL EXAM______________

HAS ANY BLOOD RELATIVE EVER HAD:

Cancer (If yes, what types?) ______________	Yes ☐	No☐
Tuberculosis	Yes ☐	No☐
Diabetes	Yes ☐	No☐
Heart Trouble	Yes ☐	No☐
High Blood Pressure	Yes ☐	No☐
Stroke	Yes ☐	No☐
Epilepsy	Yes ☐	No☐

DO YOU SMOKE? YES ☐ NO ☐

HOW MUCH? ______________________

HOW LONG? ______________________

PREVIOUS OCCUPATION ______________________

PRESENT OCCUPATION ______________________

LIST ALL MEDICATION AND DOSAGES PRESENTLY TAKEN:

LIST ALL ALLERGIES:

DO YOU HAVE ANY PROSTHESIS? Yes ☐ No☐

DO YOU REQUIRE ANTIBIOTICS PRIOR TO SURGERY? Yes ☐ No☐

PERSONAL HISTORY:

ILLNESSES: HAVE YOU EVER HAD:

PLEASE ENCIRCLE ALL ANSWERS AND STATE WHICH ONE

Measles ______________	No	Yes
German Measles ______________	No	Yes
Mumps ______________	No	Yes
Chicken Pox ______________	No	Yes
Whooping Cough ______________	No	Yes
Scarlet Fever or Scarlentina ______	No	Yes
Diphtheria ______________	No	Yes
Pneumonia ______________	No	Yes
Influenza ______________	No	Yes
Pleurisy ______________	No	Yes
Rheumatic Fever or Rheumatic Heart Disease ______	No	Yes
Arthritis or Rheumatism ______	No	Yes
Any Bone or Joint Disease ______	No	Yes
Neuritis or Neuralgia ______	No	Yes
Bursitis, Sciatica or Lumbago ______	No	Yes
Polio or Meningitis ______	No	Yes
Kidney Disease ______	No	Yes
Kidney Stones ______	No	Yes
Nephritis ______	No	Yes
Gonorrhea or Syphilis ______	No	Yes
Gallbladder Disease ______	No	Yes
Hiatal Hernia ______	No	Yes
Stomach or Peptic Ulcer ______	No	Yes
Anemia ______	No	Yes
Jaundice ______	No	Yes
Bladder Disease ______	No	Yes
Epilepsy ______	No	Yes
Migraine Headaches ______	No	Yes
Tuberculosis ______	No	Yes
Diabetes ______	No	Yes
Cancer ______	No	Yes
High or Low Blood Pressure ______	No	Yes
Colitis or other Bowel Disease ______	No	Yes
Hemorrhoids or any Rectal Disease ___	No	Yes
Nervous Breakdown ______	No	Yes
Food, Chemical or Drug Poisoning ___	No	Yes
Hay Fever or Asthma ______	No	Yes
Hives or Eczema ______	No	Yes
Frequent Infections or Boils ______	No	Yes
Any other Disease ______	No	Yes
Mitral Valve Prolapse ______	No	Yes
Other Valve Disorders ______	No	Yes
Heart Valve Problems ______	No	Yes
Heart Attacks ______	No	Yes
Stroke ______	No	Yes

INJURIES: Have you had any:

Broken or Cracked Bones ______	No	Yes
Sprains ______	No	Yes
Lacerations ______	No	Yes
Dislocations ______	No	Yes
Concussion, or Head Injury ______	No	Yes
Ever been knocked unconscious __	No	Yes

WEIGHT: Now______ One Year Ago______

Maximum______ When:______

TRANSFUSIONS: Have you ever had:

Blood or Plasma Transfusion ______ No Yes

SURGERY: Have you had:

Tonsillectomy ______	No	Yes
Appendectomy ______	No	Yes
Any other operation ______	No	Yes

Type______________ Year______________

Type______________ Year______________

Type______________ Year______________

Use space on back for any additional operations.

BREAST PATIENT QUESTIONAIRE

(Please provide us with as many answers as possible)

Patient Name______________________________ Age________

A. FAMILY HISTORY

Have you any family members affected by breast disease? Yes____ No____

If yes, whom was affected? (i.e., mother, sister, aunt etc)________________________

If yes, fibrocystic disease?__________cancer?___________

B. PERSONAL HISTORY

What was your age at the onset of the menses?____________

Have you had any children? Yes____ No___

How Many?______ How many pregnancies?_______

Age at birth of first child?________

Did you breast feed your children? Yes___ No___

Any problems with your breast during the pregnancy period? Yes___ No___

If yes, what type of problem?____________________________________

Have you ever been on female hormone therapy?

(i.e. birth control pills, premarin?) Yes___ No___

Have you ever had injury to the breast? Yes___ No___

Which one? Right___ Left___

Have you ever required a breast biopsy or aspiration? Yes___ No___

Which breast? Right___ Left___ What was the result______________________

Do you drink regular coffee, tea, caffeinated soda or eat chocolate? Yes___ No___

How much? Some____ A lot____

Do you do regular self breast exams? Yes___ No___

Do you have regular mammograms? Yes___ No___

C. PRESENT COMPLAINT *(List all that pertain)*

Has a lump been felt in the breast? Yes___ No___

If so when?__________Who felt it? Patient?___Dr?___Spouse?_____

Have you had findings appear on a mammogram? Yes___ No___

Have you had pain in the breast? Yes___ No___

If so, which one? Right___ Left?___ Is this pain new? Yes___ No___

Have you had a change in the appearance of the breast? Yes___ No___

If so, which one? Right___ Left?___

What has changed?____

Have you had any drainage or discharge from the nipple? Yes___ No___

If so, which breast? Right__ Left__ What color?_____________________

Have you had any itching or scaling of the nipple? Yes___ No___

If so, Right____ or Left____?

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR

Frequent or severe headaches ______ No Yes
Fainting spells ______ No Yes
Dizziness on change of position ______ No Yes
Unconscious spells ______ No Yes
Blurred vision ______ No Yes
Double vision ______ No Yes
Spots before eyes ______ No Yes
infected eyes ______ No Yes
Pain behind eyes ______ No Yes
Any change in vision ______ No Yes
Do you wear glasses ______ No Yes
When were they last checked ______
Earaches ______ No Yes
Discharge from ears ______ No Yes
Ringing in ears ______ No Yes
Decrease in hearing ______ No Yes
Recurrent nose bleeds ______ No Yes
Recurrent head colds ______ No Yes
Sinus trouble ______ No Yes
Hay fever ______ No Yes
Strange persistent odors ______ No Yes
Strange taste or loss in taste ______ No Yes
Persistent hoarseness ______ No Yes
Difficulty swallowing ______ No Yes
Enlarged glands ______ No Yes
Recurrent sore throats ______ No Yes
Recurrent sores in mouth ______ No Yes
Soreness or bleeding of gums on brushing ______ No Yes
Chest pain ______ No Yes
Angina pectoris ______ No Yes
Coughed up blood ______ No Yes
Pain in arm(s) ______ No Yes
Night sweats ______ No Yes
Chronic or frequent cough ______ No Yes
Chronic or frequent cough on laying down ______ No Yes
Wake up night short of breath ______ No Yes
How many bed pillows do you use ______
Shortness of breath on
Walking several blocks ______ No Yes
One flight of stairs ______ No Yes
On laying down ______ No Yes
Purple lips or fingers ______ No Yes
Palpitations or fluttering of heart ______ No Yes
High blood pressure ______ No Yes
Swelling of hands, feet or ankles ______ No Yes
At what time of day ______
Leg cramps on walking or at night ______ No Yes
Enlarged veins in legs ______ No Yes
Sores on ankles or toes ______ No Yes
Recurrent stomach pain ______ No Yes
Belching or heartburn ______ No Yes
Relieved by food or medication ______ No Yes
Appetite - Good ☐ Fair ☐ Poor ☐
Nausea or vomiting ______ No Yes
Vomited blood ______ No Yes
Avoid some foods ______ No Yes
What kinds ______
Avoid spices ______ No Yes
Abdominal cramping ______ No Yes
Color or bowel movement ______
Any blood in BM ______ No Yes
Rectal pain with bowel movement ______ No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape or texture of BM ______ No Yes
Describe ______
Pain in urinating ______ No Yes
Difficulty in starting urination ______ No Yes
Do you get up at night to urinate ______ No Yes
How many times ______
Urinate more than before ______ No Yes
Urinate less than before ______ No Yes
Any blood in urine ______ No Yes
How many times per day do you urinate ______ No Yes
Full feeling of bladder, but only small
amount of urination ______ No Yes

Lose urine on coughing or sneezing ______ No Yes
Discharge from penis ______ No Yes
Recurrent back pains ______ No Yes
Backaches ______ No Yes
Joint pains ______ No Yes
Swelling of any joints ______ No Yes
Redness or heat of any joints ______ No Yes
Tingling or weakness of hands or feet ______ No Yes
Muscle spasms ______ No Yes
Loss or change in sensation of hands ______ No Yes
Loss or change in sensation of feet ______ No Yes
Trembling of any extremity ______ No Yes
Growth in neck or throat ______ No Yes
Hot flashes ______ No Yes
Tiredness without apparent reason ______ No Yes
Brittleness of nails ______ No Yes
Dryness of skin ______ No Yes
Easy bruising ______ No Yes
Inability to stand heat ______ No Yes
inability to stand cold ______ No Yes
Change in hair texture ______ No Yes
Change in skin texture ______ No Yes
Any skin rash ______ No Yes
EKG Ever had an electrocardiogram? ______ No Yes
IMMUNIZATIONS Have you had
Smallpox vaccination within last 7 years ______ No Yes
Tetanus shots (not antitoxin which lasts only 2 weeks) ______ No Yes
Polio shots within last 2 years ______ No Yes

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset ______
Regular? Yes ☐ No ☐ Varies ☐
Cycle ______ days (from start to finish)
Flow: Heavy ☐ Medium ☐ Light ☐
Date of last period ______
Date of last pelvic exam ______
Date of last Pap test ______
Results: Neg. ☐ Pos. ☐
Any discharge from vagina? No ☐ Yes ☐
If so, color ______
amount ______
Number of pregnancies:
How many children born alive ______
How many Cesarean Sections ______

Marital Status: M S D W
Children: Yes ☐ No ☐ How Many ______

Any Additional Health Information:

GENERAL POLICY STATEMENT

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by the clinic. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due at the time of service, unless other financial arrangements are made. This includes deductibles, co-pays, and/or co-insurances. Established patients with a delinquent balance will be asked for payment at the time of service.

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral from your primary insurance care provider (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment.

Insurance Billings: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit. Charges owed due to errors, claim rejections, and/or non-response by the insurance company is the responsibility of the patient.

Medicare: Our physician is a participating provider. Although we bill Medicare as your primary insurer, you may be responsible for billing your supplemental insurance. Note that Medicare may be able to bill your supplemental insurance. Please contact them at **1-800-326-0238.**

Authorization to Release Information: I have read and I accept this policy for my testing and/or treatment with Center for Breast Care and Outpatient Surgery. The Notice of Privacy Practices for Center for Breast Care and Outpatient Surgery is prominently displayed in the clinic waiting room and I acknowledge I have seen a copy of the Notice of Privacy Practices.

Copies and fax charges:
There will be a charge for copies and faxes, five(5) pages or more will be **$1.00** a page, anything under five(5) pages will be a free service.

24 hour appointment cancellation notice:
Any appointments not kept without prior cancellation notice will be charged a **$25.00** fee.

Returned Checks:
There will be a **$30.00** fee for any checks returned from the bank.

I assign Center for Breast Care and Outpatient Surgery all payments to which I am entitled for medical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by the insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee. **MY APPOINTED AGENT OR I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.**

______________________	______________________	______________
Patient Name (print)	Patient's Signature	Date

IF THE PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is__________year(s) of age or is unable to sign because: ______________________________

______________________	______________________	______________
Signature	Relationship to the Patient	Date

Sign below if disclosure of information is not authorized:
Therefore, I agree to pay for costs of all treatments and services personally.

______________________	__________	______________________	__________
Signature of Guarantor	Date	Signature of Patient	Date