NEW PATIENT INFORMATION FORM

MERCY CLINIC BREAST SURGERY SINDELAR CANCER CENTER
10050 Kennerly Rd. Suite 1500 St. Louis MO 63128
Ph 314.525.1545
Fax 314.525.1685

NAME: ______________________________ DATE: ______________

REASON FOR
VISIT: ______________________________

REFERRED BY: ______________ PRIMARY PHYSICIAN: ______________

MEDICAL HISTORY:

Anemia	YES NO	Emphysema	YES NO	Osteopenia	YES NO
Anxiety/Depression	YES NO	Gallstones	YES NO	Osteoporosis	YES NO
Arthritis	YES NO	Glaucoma/Cataracts	YES NO	Rheumatic Fever	YES NO
Asthma	YES NO	Heartburn/Reflux	YES NO	SeasonalAllergies	YES NO
Back Problems	YES NO	Heart Disease	YES NO	Serious Injury	YES NO
Bleeding Tendency	YES NO	Hepatitis/Jaundice	YES NO	Seizure	YES NO
Blood Clots	YES NO	High Cholesterol	YES NO	Stroke	YES NO
Cancer	YES NO	Hypertension	YES NO	TB (Tuberculosis)	YES NO
Circulation Problems	YES NO	Kidney Disease	YES NO	Thyroid Problems	YES NO
Diabetes	YES NO	Mitral Valve Prolapse	YES NO	Ulcers	YES NO

OTHER MEDICAL ISSUES:

____
____
____
____
____

SURGICAL HISTORY: (Month/Year)

____
____
____
____
____

MEDICATIONS:

____
____
____
____

HOSPITALIZATIONS/BIRTHS:

____
____
____
____

MEDICATION ALLERGIES:

____
____
____
____

REACTION:

____
____
____
____

FAMILY HISTORY (ALL ILLNESSES)	LIVING	DECEASED
Father: ______________________	______	______
Mother: ______________________	______	______
Paternal Grandfather: ______________________	______	______
Paternal Grandmother: ______________________	______	______
Paternal Aunt: ______________________	______	______
Paternal Uncles: ______________________	______	______
Maternal Grandfather: ______________________	______	______
Maternal Grandmother: ______________________	______	______
Maternal Aunt: ______________________	______	______
Maternal Uncles: ______________________	______	______
Brothers: ______________________	______	______
Sisters: ______________________	______	______
Children: ______________________	______	______

ASHKENAZI JEWISH HERITAGE: YES NO

SOCIAL HISTORY:

Alcohol Use: YES NO   How much and how long? _________ Marital Status: _________________
Tobacco Use: YES NO   How much and how long? _________ Occupation: ___________________
Caffeine Use: YES NO   How much and how long? _________ Children: ______________________

HEALTH MANTENANCE:

Date of Last Period: __________   Age of First Period: ________________________________
Any Oral Contraceptives: ____________   Hormone Replacement: ______________________________
Number of Pregnancies: ______________   Number of Miscarriages: ____________________________
Age of First Delivery: ________________   Did you Breastfeed? ________________________________
Date of last Pap Smear: ______________   Date of last Mammogram: ____________________________
Have you ever taken Steroids: YES, NO   Blood thinners or transfusion? ___________________________
Date of last Bone Density: ___________   Bra Size: ____

REVIEW OF SYSTEMS: (Circle all that apply to recent issues)

GENERAL:	Weight Gain or Loss	YES NO	Fever	YES NO
	Dizziness	YES NO	Hearing Loss	YES NO
	Nose Bleeds	YES NO	Appetite Change	YES NO
	Headaches	YES NO	Vision Change	YES NO
	Hoarseness	YES NO	Thirst	YES NO
HEART AND	Breath Shortness	YES NO	Coughing	YES NO
LUNGS:	Palpitations	YES NO	Wheezing	YES NO
	Chest Pains	YES NO	Leg Swelling	YES NO
ENDOCRNE:	Heat Intolerance	YES NO	Cold Intolerance	YES NO
	Hair Gain/Loss	YES NO	Hot Flashes	YES NO
M/S:	Muscle Weakness	YES NO	Leg Pain	YES NO
	Arthritis	YES NO	Numbness/Tingling	YES NO
	Back Pain	YES NO		
BREAST:	Nipple Bleeding	YES NO	Nipple Discharge	YES NO
	Lump or Mass	YES NO	Skin Changes	YES NO
	Redness	YES NO		
GU:	Painful Urination	YES NO	Frequent Urination	YES NO
	Difficult Urination	YES NO	Nighttime Urination	YES NO
	Blood in Urine	YES NO	Urinary Incontinence	YES NO
N/P:	Mood Changes	YES NO	Depression	YES NO
G/I:	Nausea	YES NO	Constipation	YES NO
	Difficulty Swallowing	YES NO	Abdominal Pain	YES NO
	Vomiting	YES NO	Heartburn	YES NO
	Blood in Stool	YES NO	Bowel Incontinence	YES NO
	Diarrhea	YES NO	Choking	YES NO
	Hemorrhoids	YES NO		

Primary Care Provider: ____________________
Referred By: ____________________

Patient Information

NAME: *(Last)* ____________ *(First)* ____________ (MI) ______ PREVIOUS NAME: ____________

ADDRESS: ____________ *(City/State)* ____________ (Zip) ______

HOME PHONE: (____) ____________ CELL PHONE: (____) ____________ WORK PHONE: (____) ____________ *(Ext)*

DATE OF BIRTH: ____/____/____ SEX: M F T MARITAL STATUS: S M D W Separated SOC. SEC. NO. ____/____/____

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED UNEMPLOYED STUDENT STATUS: FULL TIME PART TIME NOT A STUDENT

E-MAIL ADDRESS: ____________

NAME OF GUARANTOR: ____________ GUARANTOR'S DATE OF BIRTH: ____/____/____

GUARANTOR'S ADDRESS: ____________ *(City/State)* ____________ *(Zip)* ______

TELEPHONE NUMBER: (____) ____________ SOC. SEC. NO. ____/____/____ RELATIONSHIP TO PATIENT: ____________

EMERGENCY CONTACT: ____________ TELEPHONE NO: (____) ____________ RELATIONSHIP: ____________

Insurance Information

PRIMARY INSURANCE: ____________ ☐ CARD PROVIDED EFFECTIVE DATE: ____/____/____

NAME OF INSURED: ____________ RELATIONSHIP TO PATIENT: ____________

INSURED'S DATE OF BIRTH: ____/____/____ INSURED'S ID NO. ____________ GROUP NO. ____________

INSURED'S ADDRESS: ____________ TELEPHONE NO. (____) ____________
(If Different From Patient's)

INSURED PARTY EMPLOYED BY: ____________

EMPLOYER'S ADDRESS: ____________ TELEPHONE NO. (____) ____________

SECONDARY INSURANCE: ____________ ☐ CARD PROVIDED EFFECTIVE DATE: ____/____/____

NAME OF INSURED: ____________ RELATIONSHIP TO PATIENT: ____________

INSURED'S DATE OF BIRTH: ____/____/____ INSURED'S ID NO. ____________ GROUP NO. ____________

INSURED'S ADDRESS: ____________ TELEPHONE NO. (____) ____________
(If Different From Patient's)

INSURED PARTY EMPLOYED BY: ____________

EMPLOYER'S ADDRESS: ____________ TELEPHONE NO. (____) ____________

Additional Information

ADVANCED DIRECTIVES: ☐ Y ☐ N POWER OF ATTORNEY: ☐ Y ☐ N

LOCAL PHARMACY: ____________ PHONE: ____________ MAIL ORDER PHARMACY: ____________

PATIENT DEMOGRAGHICS: The St. Anthony's Physician Organization is participating in Meaningful Use, a new nationwide initiative to improve the health of our nation. To better identify possible disparities in access and quality of healthcare based on race and ethnicity on a nation wide level, we are required to ask the following demographic questions:

Please select all that apply:

RACE
- ☐ AMERICAN INDIAN/ALASKA NATIVE
- ☐ ASIAN
- ☐ AFRICAN AMERICAN
- ☐ CAUCASIAN
- ☐ HISPANIC
- ☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLAND
- ☐ OTHER
- ☐ I PREFER NOT TO REPORT

ETHNICITY
- ☐ BOSNIAN
- ☐ HISPANIC/LATINO
- ☐ NOT HISPANIC/LATINO
- ☐ I PREFER NOT TO REPORT

PREFERRED LANGUAGE
- ☐ BOSNIAN
- ☐ ENGLISH
- ☐ SIGN LANGUAGE
- ☐ SPANISH
- ☐ OTHER
- ☐ I PREFER NOT TO REPORT

SIGNATURE OF RESPONSIBLE PARTY: ____________ **DATE:** ____/____/____

PHI Communication Form

Patient Identification

Printed Name: ______________________ Date of Birth: ______________________

Address: ______________________ Last 4 digits of SSN: ______________________

______________________ Telephone: ______________________

I, ______________________, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Mercy will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information*** form is completed or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: ______________________ Date: __________
Signature

Patient or Legal Personal Representative: ______________________
Printed Name

Authority of Personal Representative: ______________________

Patient Name:
MRN#:
Date of Birth: