ALASKA BREAST CARE SPECIALISTS

KAREN S. BARBOSA, D.O.
BOARD CERTIFIED
FELLOWSHIP TRAINED
BREAST SURGEON

2741 DEBARR ROAD SUITE C 402
ANCHORAGE, AK 99508

PHONE: (907) 222-2950
FAX: (907) 222-5950

OFFICE VISIT INFORMATION — PAGE ONE

Welcome to Alaska Breast Care Specialists, P.C. In order to facilitate your visit today, please take a moment to complete the form below and list any questions you would like addressed.

Name: _____ Nickname: _____ Birthdate: _____ Age: _____

Marital Status: _____ Race: _____ Height: _____ Weight: _____ Occupation: _____

Primary Doctor: _____ OBGYN: _____

How did you come to Dr. Barbosa's practice?

☐Referral by Physician: _____ ☐ Self-referral ☐ Friend ☐ Other _____

What brings you to the office today? _____

Are you currently experiencing any of the following? (Circle all that apply)

Abnormal mammogram:	Right	Left	Both
Breast lump:	Right	Left	Both
Lump under arm:	Right	Left	Both
Nipple discharge:	Right	Left	Both
Breast pain:	Right	Left	Both

Please rate your pain on a scale of 1-10 (10 being the worst): _____

How do you monitor your breasts every year? (Check all that apply)

☐ A Physician examines my breasts every year

☐ Mammogram Frequency: _____ Date of last: _____

☐ Breast MRI Date: _____

☐ Self examination: ☐ Monthly ☐ Occasionally ☐ Never

What is your bra size? _____

Have you had any of the following in the past? (Check all that apply)

☐ Breast biopsies: Year _____ Right Left Both

Year _____ Right Left Both

Did a biopsy ever show atypical ductal hyperplasia (ADH)? Right Left Both

Did a biopsy ever show atypical lobular hyperplasia (ALH) Right Left Both

☐ Breast cysts Year _____ Right Left Both

☐ Breast implants Year _____ Right Left Both

☐ Breast reduction Year _____ Right Left Both

☐ Breast cancer Year _____ Right Left Both

ALASKA BREAST CARE SPECIALISTS

OFFICE VISIT INFORMATION — PAGE 2 PATIENT NAME: _____

How was it treated?

☐ Lumpectomy ☐ Mastectomy By whom? _____

☐ Breast reduction By whom? _____ What type? _____ Year _____

☐ Radiation By whom? _____

☐ Chemotherapy By whom? _____

☐ Anti-estrogen pills (e.g. Tamoxifen, Armidex, Femara) By whom? _____

Have you had any other type of cancer? ☐ Yes ☐ No

What type: _____ Year _____

Did you receive radiation? ☐ Yes ☐ No

Did you receive chemotherapy? ☐ Yes ☐ No

Do you experience any of the following currently or occasionally? (Circle all that apply)

Glasses	CHF	IBF	Easy bruising
Hearing aid	Pacemaker	Ulcers	Fatigue
False teeth	Cough	Bloating	Blood in sputum
Difficulty swallowing	Shortness of breath	Change in stool	Vaginal spotting or bleeding
Sinusitis	Asthma	OA	Tender/enlarged lymphnodes
Chest pain	Brochitis	ROM restrict	Night Sweats
Afb	Lack of appetite	Ringing in ears	Menstrual irregularities
Arrhythmia	Abdominal pain	Hot flashes	Change in weight
Murmur	Reflux	Other: _____	

Regarding your health, have you been or are you being treated for: (Check all that apply)

☐ High blood pressure	☐ Depression	☐ Stroke
☐ Increased cholesterol	☐ Diabetes	☐ Anxiety
☐ CHF	☐ Heart attack	☐ Glasses
☐ Bronchitis/pneumonia	☐ Atrial fibrillation	☐ Sinuses
☐ Reflux	☐ Asthma	☐ Murmur
☐ Liver disease	☐ Ulcers	☐ Pacemaker
☐ Blood clots	☐ Kidney disease	☐ Rom restriction
☐ IBS	☐ Arthritis, rheumatoid, or osteoporosis	

Have you had any other surgery? (use back of page if necessary)

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

ALASKA BREAST CARE SPECIALISTS

OFFICE VISIT INFORMATION — PAGE 3

PATIENT NAME: _____

Please list all medications: (use back of page if necessary)

Medication	Dose	Route	Frequency

Are you allergic to any medications? ☐ Yes ☐ No

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Do you have a latex allergy? ☐ Yes ☐ No

Do you take any herbal supplements? Please list: _____

Do you take: ☐ Multi-vitamin ☐ Calcium ☐ Vitamin D ☐ Omega-3

If applicable to you:

Age when menstrual cycle began (usually 12-13): _____

Date of last menses: _____

Age at first live birth: _____

Number of pregnancies: _____ Number of children born: _____

Did you breast feed? ☐ Yes ☐ No For how long? _____

Age at menopause: _____

Do you still have your uterus? ☐ Yes ☐ No

Do you still have your ovaries? ☐ Yes ☐ No

Are you currently taking or have you ever taken any of the following hormonal medications?

☐ Birth control pills Dates taken: _____ Side effects: _____

☐ Estrogen Dates taken: _____ Side effects: _____

☐ Progesterone Dates taken: _____ Side effects: _____

☐ Combination Dates taken: _____ Side effects: _____

☐ Other: Dates taken: _____ Side effects: _____

Are you of Ashkenazi Jewish ancestry? ☐ Yes ☐ No ☐ Unknown ☐ Adopted

Has any blood relative had breast cancer? ☐ Yes ☐ No ☐ Unknown ☐ Adopted

Relationship	Maternal	Paternal	Age at diagnosis	One or both affected	Current status of relative
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____

ALASKA BREAST CARE SPECIALISTS

OFFICE VISIT INFORMATION — PAGE 4 PATIENT NAME: _____

Has any blood relative had ovarian cancer?

Relationship	Maternal	Paternal	Age at diagnosis	Treatment received	Current status of relative
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____

Has any blood relative had any other type of cancer?

Relationship	Maternal	Paternal	Age at diagnosis	Type of cancer	Current status of relative
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____

Has any blood relative had osteoporosis, stroke, heart attacks, blood clots, or thyroid disease?

Relationship	Maternal	Paternal	Diagnosis	Age at diagnosis	Current status of relative
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____

Have you ever smoked? ☐ Yes ☐ No

If yes, please indicate amount and duration:

Packs per day: _____ Years: _____

Are you currently smoking? ☐ Yes ☐ No When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Never

Do you eat foods or drink beverages containing caffeine? (e.g. coffee, tea, chocolate)

☐ Yes ☐ No

How would you rate your stress level?

☐ Extreme ☐ Moderate ☐ Minimal

Do you exercise?

☐ Never ☐ Sometimes ☐ 30 minutes 5 times per week or more

Do you have any questions you would like answered at your visit?

1) _____

2) _____

3) _____

Thank you! We look forward to meeting you.

ALASKA BREAST CARE SPECIALISTS

KAREN S. BARBOSA, D.O.
BOARD CERTIFIED
FELLOWSHIP TRAINED
BREAST SURGEON

2741 DEBARR ROAD SUITE C 402
ANCHORAGE, AK 99508

PHONE: (907) 222-2950
FAX: (907) 222-5950

PATIENT INFORMATION

Patient Name: _____ ☐ Female ☐ Male ☐ Other: _____

Patient Date of Birth: _____ **Previous Name (if applicable):** _____

Social Security Number: _____ **Driver's License Number:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____ ☐ Permission to leave message

Cell Phone: _____ ☐ Permission to leave message

Work Phone: _____ ☐ Permission to leave message

Email Address: _____ ☐ I do not have an email address

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian ☐ Decline to Provide

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Provide

Language: ☐ English ☐ Other: _____

ALASKA BREAST CARE SPECIALISTS

NEW PATIENT INTAKE SHEET

Name: _____ Date of Birth: _____ Sex: _____ Marital Status: _____

Social Security Number: _____ Driver's License Number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #(s): Home: _____ Work: _____ Cell: _____

Emergency contact: _____ **Phone:** _____

Relationship to Patient: _____ Other: _____

Referring Doctor: _____ **Phone:** _____

Primary Care Doctor: _____ **Phone:** _____

OBGYN: _____ **Phone:** _____

REASONS FOR YOUR VISIT: _____

Insurance Information:

Primary insurance: _____

Address: _____

_____

Phone: _____

ID #: _____

Group #: _____

Subscriber: ☐ Self ☐ Other

Subscriber name: _____

Relationship: _____ DOB: _____

SSN: _____

Phone: _____

Address: _____

_____

Secondary Insurance: _____

Address: _____

_____

Phone: _____

ID #: _____

Group #: _____

Subscriber: ☐ Self ☐ Other

Subscriber name: _____

Relationship: _____ DOB: _____

SSN: _____

Phone: _____

Address: _____

_____

Local Pharmacy: _____ **Phone:** _____

Address: _____ City: _____ State: _____ ZIP: _____

I verify that my demographic information is correct by my signature below:

Signature: _____ **Date:** _____

HIPAA CONSENT

Patient Record Disclosures

The HIPAA Privacy Rule exists to protect patients' privacy. The Rule allows the disclosure of health information without a patient's consent for the purposes of *treatment, payment, and healthcare operations*. However, the Rule requires healthcare providers to take reasonable steps to limit the use, disclosure, and request for personal health information to the *minimum necessary* to accomplish the intended purpose.

Under HIPAA, you have the right to to view and obtain copies of your medical record, request that necessary corrections be made to your record, make requests to limit the health information we use or share, and get a list of those with whom we have shared information. HIPAA also allows you to designate individuals to exercise your rights and make choices about your health information on your behalf. You may also specify your preferred modes of communication and the allowed contents of this communication.

Please feel welcome to ask us for a full copy of the Notice of Privacy Practices for HIPAA.

I wish to be contacted in the following manner: (check all that apply)

☐ Home Telephone: _____
- ☐ OK to leave a message with details
- ☐ Leave a message with call-back number only

☐ Cell phone: _____
- ☐ OK to leave a message with details
- ☐ Leave a message with call-back number only

☐ Work Telephone: _____
- ☐ OK to leave a message with details
- ☐ Leave a message with call-back number only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work address
- ☐ OK to fax to this number: _____

I give authorization to leave a message in my absence with: _____

Relationship to patient: _____

For matters regarding:
- ☐ my appointment reminders
- ☐ my account, such as billing and balances due
- ☐ my treatment/test results

I acknowledge that I have read and understand the Notice of Privacy Practices for HIPAA. I understand Alaska Breast Care Specialists, PC is allowed to use and disclose my health information for the purposes of treatment, payment, and healthcare operations.

_____ Patient Name (Print)

_____ Birthdate

_____ Signature

_____ Date

ALASKA BREAST CARE SPECIALISTS

KAREN S. BARBOSA, D.O.
BOARD CERTIFIED
FELLOWSHIP TRAINED
BREAST SURGEON

2741 DEBARR ROAD SUITE C 402
ANCHORAGE, AK 99508

PHONE: (907) 222-2950
FAX: (907) 222-5950

GENERAL CONSENT TO TREATMENT

I hereby authorize **ALASKA BREAST CARE SPECIALISTS** physician and staff to provide examination and/or evaluations, treatments, etc. as deemed necessary and in accordance with sound medical procedures. I hereby consent to such treatment and procedures with the understanding that treatment and procedures that involve significant risk will not be performed without prior, specific informed consent.

I understand that as part of the provision of my healthcare services by **ALASKA BREAST CARE SPECIALISTS** physician and staff, health information is collected, compiled and maintained in my medical record. This information includes a description of my health history, physical examinations, test results, surgical reports, pathology and other laboratory reports, medications, treatment plans and communications among the healthcare staff.

I understand that this information is used as a source for my treatment and care, for preparation of my bill, for verification by my insurance carrier or a third-party payer that services were billed correctly and for routine healthcare operations of the facility such as conducting planning and auditing functions.

I am aware that Dr. Barbosa is not a plastic surgeon, but has had training in oncoplastics since 2008. Oncoplasty is plastic surgery directed at optimizing cosmetic outcomes. I am aware that my de-identified pictures may be used for teaching purposes.

I understand that I have the right to revoke this consent in writing except that **ALASKA BREAST CARE SPECIALISTS** physician and staff has already taken action in reliance on the consent.

The undersigned certifies that he/she has read the above and is the patient, parent, guardian, or representative authorized to execute the above and accept its terms.

_____
Patient Name (Print)

_____
Witness Signature

_____
Signature of Patient
(or Person authorized to consent for patient)

_____
Relationship to Patient or Person

_____
Date