RACHEL P. DULTZ, MD, FACS
BREAST SURGICAL SPECIALIST, LLC

Welcome to my practice, **Rachel P. Dultz, MD, FACS**, **Breast Surgical Specialist, LLC**. I am a Fellowship trained Breast Surgical Oncologist and a board-certified surgeon and fellow of the American College of Surgeons (FACS). Thank you for choosing this practice to help with your medical needs.

The office is located in 300B Princeton-Hightstown Rd (Route 571) in the East Windsor Medical Commons complex just west of Route 133. The office is only several miles from Princeton, West Windsor, Plainsboro, Cranbury and Hightstown.

In order to provide the best service for our patients at the time of their visit, please bring the following information and completed forms to your scheduled appointment:

1. Insurance is the responsibility of the patient and every patient must have all of their insurance cards with them so the office can make a copy.
2. Each patient should have a referral form from their primary physician, if required by their insurance carrier.
3. If you are not sure you require a referral, please contact your insurance carrier prior to your visit.
4. Please bring all x-rays to your appointment including new and old mammograms, ultrasounds and MRIs. Please bring actual films, not a disc if possible.
5. Please complete the Registration Packet which includes the following forms (all forms can be downloaded from our web site at www.racheldultzmd.com/forms.htm):
   - ❑ Registration Form
   - ❑ Medical History Form
   - ❑ Breast Information Sheet
   - ❑ Patient Authorization Form
6. Payment for the visit is expected at the time of the visit. This includes co-pays. Our staff will submit the claims. For non-participating insurances, full payment is due at the time of the visit. This office accepts personal checks, credit cards (Visa, MasterCard and Discover) and cash.
7. If you need to cancel your appointment, please give us at least 24 hours notice, as we do have patients awaiting appointments. There will be a $75 charge for all appointments not cancelled within 24 hours prior.

The practice of Breast Surgical Specialist, LLC once again welcomes you and sincerely thanks you for giving us the opportunity to take care of you. If you are unable to keep your appointment, please call and let us know.

300B Princeton-Hightstown Rd, Suite 102, East Windsor, NJ 08520
(609) 688-2729 Phone (609) 688-2709 Fax
www.racheldultzmd.com

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Registration Form

Today's Date:	Referring Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle I.:	
Marital Status: ❑ S ❑ M ❑ W ❑ D	Sex: ❑ M ❑ F		
Social Security #:	Birth date:	Age:	Email Address:
Street Address:	Home phone #:	Cell Phone #:	
P.O. Box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone #	

INSURANCE INFORMATION

Person Responsible for Bill:	Birth Date:	Address (if different):	Home Phone #:
Is this person a patient here? ❑ Yes ❑ No	Occupation:		
Employer:	Employer Address:	Employer Phone #	
Is this patient covered by insurance?	❑ Yes ❑ No		
Primary Insurance:	Subscriber's Name:		
Subscriber's S.S.#:	Birth Date:	Group #:	Policy #: Co-payment:
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Secondary insurance (if applicable):	Subscriber's name:	Birth Date:	Social Security #:
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other	Group#:	Policy #:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Home Phone #:	Work Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Breast Surgical Specialist, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Breast Information Sheet

First Name: _____ Last Name: _____ Age: _____ Date: _____

FAMILY HISTORY OF BREAST CANCER			
Family History of Breast Cancer ❑ Yes ❑ No	❑ Mother ❑ Sister(s) ❑ Grandmother ❑ Aunt(s) ❑ Daughter ❑ Cousin(s) ❑ Other		
PERSONAL HISTORY			
Menstrual History:	Age at Onset:	Age at Menopause:	Date of Last Menstrual Period:
Hormonal Therapy:	Oral Contraceptive:		
	Hormone Replacement Therapy:		
Childbirth History:	# of Pregnancies:	# of Children:	
	Age at First Childbirth:	Breastfeed: ❑ Yes ❑ No	
BREAST IMAGING			
Mammogram: ❑ Yes ❑ No	Date of Last:		
Sonogram: ❑ Yes ❑ No	Date of Last:		
MRI: ❑ Yes ❑ No	Date of Last:		
REASON FOR VISIT			
Lump:	❑ Right ❑ Left	Duration of Complaint:	
Pain:	❑ Right ❑ Left	Duration of Complaint:	
Nipple Discharge:	❑ Right ❑ Left	Duration of Complaint:	
Change in Breast Appearance	❑ Right ❑ Left	Duration of Complaint:	
Abnormal Mammogram:	❑ Right ❑ Left	Duration of Complaint:	
Second Opinion:			
BREAST CANCER TREATMENTS			
Lumpectomy:	❑ Yes ❑ No	❑ Right ❑ Left	
Radiation:	❑ Yes ❑ No		
Mastectomy:	❑ Yes ❑ No	❑ Right ❑ Left	
• Without Reconstruction	❑ Yes ❑ No		
• With Reconstruction	❑ Yes ❑ No		
Chemotherapy	❑ Yes ❑ No		

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Medical History p.1

First Name: _____ Last Name: _____ Age: _____ Date: _____

CHIEF COMPLAINT/REASON FOR VISIT
Please describe:

PAST MEDICAL HISTORY (check all that apply)	
Blood/Oncology:	❑ Anemia ❑ Bleeding Disorder ❑DVT or clots ❑Cancer (type _____)
Cardiac:	❑ High Blood Pressure ❑ Heart Disease ❑ Stroke ❑ Atrial Fib ❑ MVP
Endocrine:	❑ Diabetes ❑ High Cholesterol/Triglycerides ❑ Gland Disorder (thyroid/parathyroid, pituitary, adrenal)
Eyes/Ears/Nose:	❑Glaucoma ❑ Macular Degeneration ❑ Cataracts ❑ Hearing Loss ❑Nasal Allergies
GI tract:	❑Gallstones ❑ Hepatitis ❑ Ulcers ❑ Acid Reflux Disease ❑ GI Bleeding ❑ Diverticulitis
Joints:	❑ Osteoporosis ❑ Arthritis ❑ Rheumatoid Arthritis ❑ Lupus ❑ Gout ❑ Joint replacement
Nervous:	❑ Headaches ❑Psychiatric Illness
Reproductive:	❑ Irregular Periods
Respiratory:	❑ Asthma ❑Tuberculosis/Positive TB test ❑ Emphysema/COPD ❑ Pneumonia
Urinary:	❑ Frequent Urinary Infections ❑ Kidney Stones ❑Kidney Disease
Other:	

ALLERGIES (Drugs, latex, food and adhesive)
Please list:

Medications: (Including OTC medicines and vitamins/supplements. Please attach list if necessary)	
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:

Pharmacy		
Name:		
Address:		Phone #:

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Medical History p.2

First Name: _____ Last Name: _____ Age: _____ Date: _____

PAST SURGICAL HISTORY	
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:

FAMILY MEDICAL HISTORY			
Relationship:	**Alive or Deceased:**	**Age:**	**Diseases:**
	❑ Alive ❑ Deceased		
	❑ Alive ❑ Deceased		
	❑ Alive ❑ Deceased		
	❑ Alive ❑ Deceased		
	❑ Alive ❑ Deceased		

SOCIAL HISTORY			
Smoking:	❑ Yes ❑ No	Packs/Day:	Years:
Former Smoker:	❑ Yes ❑ No	How many years:	When did you quit?
Exercise:	❑ Yes ❑ No	Type:	Frequency:
Caffeine on a Regular Basis:	❑ Yes ❑ No	Cups/Day:	
Alcohol Intake:	❑ Yes ❑ No	❑ Daily ❑ Weekly ❑ Occasionally	

REVIEW OF SYSTEMS (check all that apply)	
Breasts:	❑ pain ❑ lumps ❑nipple discharge ❑skin changes ❑self-examination
Cardiovascular:	❑ chest pain/angina ❑ hypertension ❑ heart murmurs ❑SOB while walking or sleeping ❑ palpitations ❑claudication ❑ leg cramps ❑ history of DVT ❑ peripheral edema
Ears/Nose:	❑ hearing loss or ringing ❑vertigo ❑discharge ❑stuffiness ❑ bleeding ❑itching
Endocrine:	❑ thyroid disease ❑heat or cold intolerance ❑ excessive thirst or urination ❑ diabetes
Eyes:	❑ vision problems ❑glasses/contacts ❑ pain ❑double vision ❑glaucoma
Gastrointestinal:	❑ loss of appetite ❑heartburn ❑abdominal pain ❑ nausea or vomiting ❑change in bowel habits ❑constipation ❑diarrhea ❑hemorrhoids ❑rectal bleeding/blood in stool
General:	❑ fevers ❑sweats ❑ weight change ❑energy level ❑exercise tolerance headaches
Genitourinary:	❑ frequent urination ❑burning or painful urination ❑ blood in urine ❑ kidney stones ❑periods irregular /heavy
Hematologic:	❑ anemia ❑bleeding problems ❑ bruise easily ❑ prior transfusions ❑enlarged glands
Mouth/Throat:	❑ dentures ❑dental pain ❑sore throat ❑ bleeding gums ❑ tongue pain ❑voice change
Musculoskeletal:	❑joint or back pain ❑muscle aches ❑stiffness ❑swelling ❑ deformity
Neck:	❑pain/stiffness ❑ lumps ❑swollen glands ❑ thyroid problems
Neurologic:	❑weakness ❑numbness ❑tingling ❑dizziness/lightheadedness seizures ❑gait problems ❑speech difficulties ❑memory problems
Psychiatric:	❑depression ❑memory loss
Respiratory:	❑cough ❑sob ❑sputum (describe) ❑wheezing ❑ pleuritic chest pain ❑apnea
Skin:	❑rashes ❑ lumps ❑ sores ❑itching ❑hair-nail changes ❑changing moles

Height:		**Weight:**		

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Patient Authorization for Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 controls how the protected health information (PHI)of our patients can be discussed and with whom. This form authorizes me and my staff to discuss your PHI with those you have listed below and in what specific manner.

INDIVIDUALS TO WHOM YOUR HEALTH INFORMATION MAY BE DISCLOSED	
Check all that apply:	
❑ Spouse	Name:
❑ Parent	Name:
❑ Parent	Name:
❑ Child	Name:
❑ Child	Name:
❑ Other	Name:

CONTACT INFORMATION		
Can a message be left on an answering machine?		**What kind of information can be disclosed?** (check all that apply)
Home	❑ Yes ❑ No	❑ All at doctor's discretion ❑ Medical History
Work	❑ Yes ❑ No	❑ Diagnosis ❑ Treatment ❑ Surgical Information
Cell	❑ Yes ❑ No	❑ Billing/Insurance Information ❑ Only return a call message
		❑ Other

The Patient has the right to revoke this authorization in writing, except to the extenet that action has been taken in reliance on this authorization. This authorization will remain in effect unless otherwise revoked by the patient. Release of the PHI covered by this authorization will be disclosed solely for the purpose of keeping designated family members informed of your healthcare condition.

Patient First Name: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____

Patient Signature: _____ Date: _____

PATIENT DEMOGRAPHIC INFORMATION	
In order to comply with Meaningful Use (OBJ-304C), it is required to capture the following patient information. Please check all that apply.	
Race	❑ American Indian/Native Alaskan ❑ Asian ❑ Native Hawaiian/Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race ❑ Prefer not to answer
Ethnicity	❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Prefer not to answer
Language	❑ English ❑ Indian (Hindu/ Tamil) ❑ Spanish ❑ Chinese ❑ Russian ❑ Other _____ ❑ Prefer not to answer

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operation

I understand that as part of my health care, Rachel P. Dultz, M.D. Breast Surgical Specialist, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care options

I understand that Rachel P. Dultz, M.D. Breast Surgical Specialist, LLC is not required to agree to restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted in Section 164.506 of the Code of Federal Regulations.

I further understand that Rachel P. Dultz, M.D. Breast Surgical Specialist, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Copy of Federal Regulations. Should Rachel P. Dultz, M.D. Breast Surgical Specialists, LLC change this notice, they will send a copy of any revised notice to the address I have provided (whether U.S. Mail or, if I agree, email).

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.