Bridge Breast and Aesthetic Surgery Center
608 Medical Care Drive
Brandon, FL 33511
(813) 684-2506

Please read over and fill out this packet completely. It is very important that you bring this packet with you to your appointment. If you do not, you will have to fill out another one, which will cause a delay in your appointment. Please remember to bring your insurance card and some form of ID.

Please arrive at least 10 minutes early, if you are more than 15 minutes late we will have to reschedule your appointment

If you need to cancel your appointment for any reason, please give us at least a 24 hour notice. Our office does have a no show fee of $25.00.

All charges (i.e. copays, coinsurance) will be collected prior to any services rendered, including, but not limited to, office visits, in office procedures and surgeries.

For patients scheduled with Dr. Donna Bridge, please remember to bring any recent imaging (mammogram, ultrasound or MRI) and reports to your appointment. These may be obtained by contacting your imaging center and requesting a copy be made for you to pick up prior to your scheduled appointment.

Thank you for choosing Bridge Breast & Aesthetic Surgery Center, we look forward to seeing you soon!

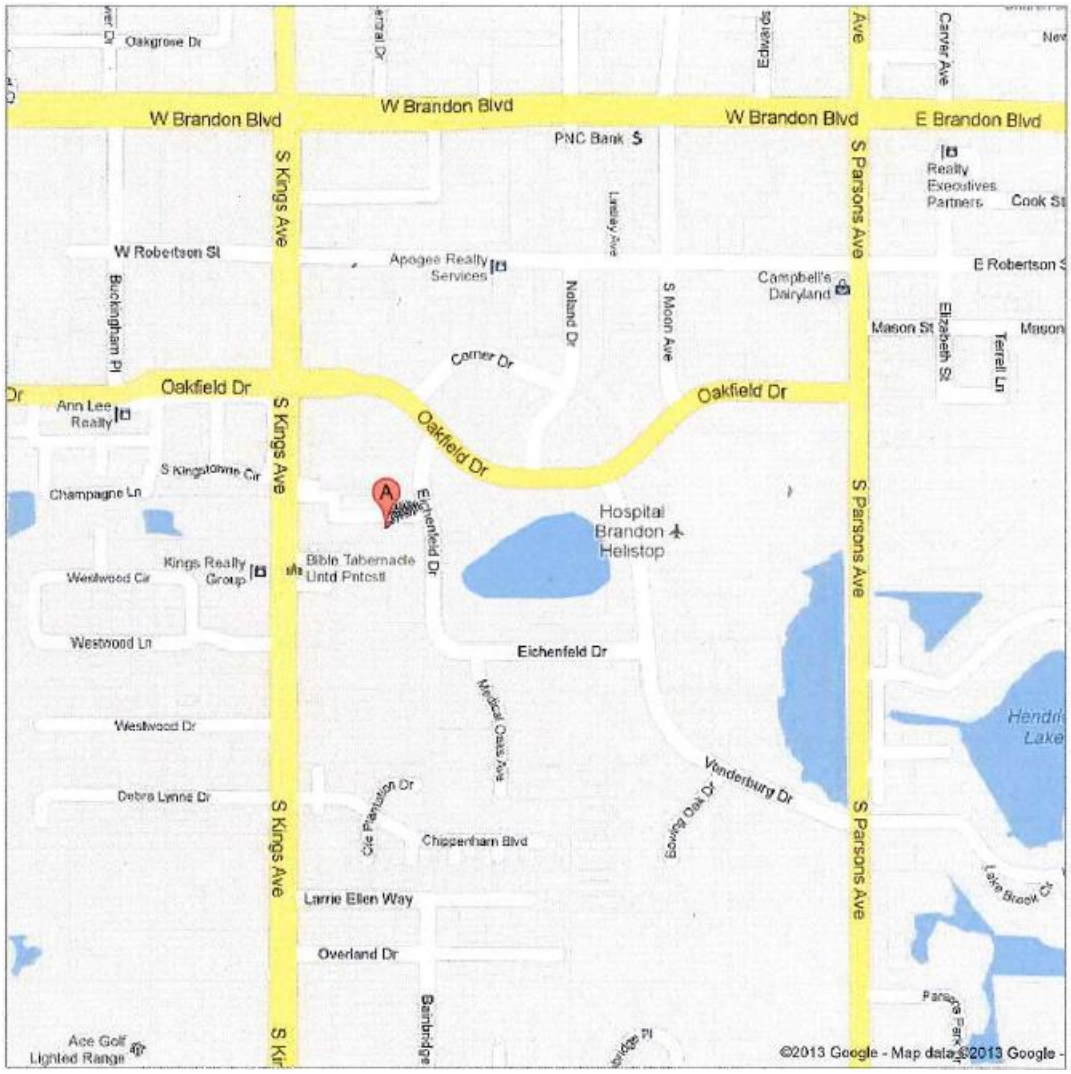
Drs. Peter & Donna Bridge and Staff

Directions:

From Tampa take State Road 60 going east into Brandon. Take a right on Kings Ave. Go to the 2nd light which is Oakfield and take a left. Take a right on Eichenfeld Drive. (1st street on right). We are the first street on the right. (Medical Care Drive).

From Lakeland/Valrico take State Road 60 going west into Brandon. Take a left on Kings Ave. Go to the 2nd light which is Oakfield and take left. Take a right on Eichenfeld Drive. (1st street on right). We are the first street on the right. (Medical Care Drive).

From Lumsden go north on Kings Ave. Medical Care Drive is on the right hand side of the road. (It is before you get to Lifestyles gym at the corner of Oakfield and Kings). Follow Medical Care Drive and we are on the right. (608 Medical Care Drive).



Peter Bridge, MD & Donna Bridge, MD
HIPPA Privacy Policy
Effective November 22, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Dr. Peter or Donna Bridge at 813-684-2506. This notice describes the privacy practices at our office.
We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the notice currently in effect.
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How we may use and disclose your health information: Described as follows are the ways we may use and disclose your health information. Except for the following purposes, we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Dr. Peter or Donna Bridge.
Treatment: We may use and disclose your health information so that others or our office may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.
Health Care Operations: We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.
Appointment reminders, treatment alternatives and health related benefits and services: disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health related benefits and services you could use.
Individuals involved in your care or payment for your care: when appropriate, we may share your health with a person involved in or paying for your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief. As required by law we will disclose your health information when required to do so by international, federal, state or local law. To avert a serious threat to health & safety we may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.
Business Associates: we may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.
Military and Veterans: If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.
Public Health Risks: We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.
Health Oversight Activities: We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law enforcement: We may release your health information requested by a law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of a criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in custody: If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care; 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to inspect and copy: You have the right to inspect and copy your medical and billing records by written request to Dr. Peter or Donna Bridge. Right to Amend: You have the right to request an amendment to your records by written request to Dr. Peter or Donna Bridge. Right to Accounting of disclosures: You have a right to an accounting of certain disclosure by written request to Dr. Peter or Donna Bridge. Right to Request restrictions: You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Dr. Peter or Donna Bridge. WE are not required to agree with your request, but we will try to comply. Right to Request confidential communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and should be addressed to Dr. Peter or Donna Bridge. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Dr. Peter and Donna Bridge:

Drs. Peter and Donna Bridge
608 Medical Care Drive
Brandon, Florida 33511
684-2506

BRIDGE BREAST & AESTHETIC SURGERY CENTER

Registration Form (Please print)

Today's date:			**HIPPA POLICY RECIEVED: INITIAL FOR YES _____**			
PATIENT INFORMATION						
Patient's last name: First Middle:		☐ Mr. ☐ Mrs	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? ☐ Yes ☐ No If not, what is your legal name?	Email address:			Birth date:	Age:	Sex: ☐M ☐F
*Street address:	Social Security no.:			Phone: ( )		
P.O. Box:	City:	State:	ZIP code:			
Occupation:	Employer:	Employer phone: ( )				
Chose clinic because/Referred to clinic by (please check one box): Dr. _____ ☐Insurance Plan ☐Hospital ☐Family ☐Friend ☐Close to home/work ☐Yellow Pages ☐Other						
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscribers name:	Subscribers S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Specialist Copay:
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patients relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home or Cell: ( )	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 Bridge Breast & Aesthetic Surgery Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

PRIMARY CARE PHYSICIAN: _____ Phone: _____

ONCOLOGIST: _____ Phone: _____

CARDIOLOGIST: _____ Phone: _____

OB/GYN: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

People we are authorized to speak to about your medical care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Assignment & Release

I certify that the above information is correct to the best of my knowledge. I give Dr. Bridge consent to treat me. I will not hold Dr. Bridge or any member of the staff responsible for any errors that may have been made in the completion of this form. I hereby authorize the release of all medical records to Dr. Bridge that may be useful in my treatment and authorize the release of my medical records to any physician/insurance company requesting them.

_____ _____

Signature **Date**

I certify that I have insurance with _____, and assign directly to Dr. Bridge all insurance benefits, if any, payable for services rendered. I understand that I am financially responsible for all charges incurred. I understand that I am responsible for any collection fees that incur should that become necessary. I authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature **Date**

I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. In Medicare cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge and the patient if responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

_____ _____

Signature **Date**

We will bill those insurance companies with which we have an agreement and will require you to pay the authorized copayment/coinsurance at the time of service. In the event your health plan determines a service to be 'not covered', you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office or billing company. Surgery patients will be expected to pay their responsible amount in full before the time of surgery. If payment arrangements need to be made, please consult our Office Manager or billing company. We are dedicated to providing the best possible care and your complete understanding of your financial responsibilities is an essential element of your care and treatment.

_____ _____

Signature **Date**

Name: _____ **Date:** _____

Reason for visit: _____

BREAST HISTORY I

Number of children: _____

Your age when first child was born: _____

How old were you when you had your first period? _____

Did you breast feed? ☐ Yes ☐ No

Are you currently taking estrogen? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

Status of Menopause: ☐ Premenopausal ☐ Postmenopausal ☐ Perimenopausal

☐ Premenarchy (have not started to have periods)

Do you have any relatives with breast cancer: ☐ Yes ☐ No

If yes, how are they related to you? _____

_____

CURRENT MEDICATIONS

_____ _____

_____ _____

PAST MEDICAL HISTORY:

Do you have any of the following:

____ Hypertension ____ GI reflux ____ Asthma ____ Depression

____ Heart Disease ____ Ulcers ____ High Cholesterol ____Emphysema/COPD

____ HIV/AIDS ____ Hepatitis ____ Liver disease ____ Alcohol abuse

____ Seizures ____ Anemia ____ Drug abuse

____ Diabetes *(If yes, are you on insulin?)* ____ Cancer *(If yes, specify type)*: _____

_____

Other medical problems:_____

_____

ALLERGIES (Give reaction as well): _____

_____

_____

ARE YOU ALLERGIC TO (circle any that apply): **Shellfish** **Peanuts (legumes)** **Eggs** **Latex**

SURGICAL HISTORY

Year Type of Surgery	Year Type of Surgery	Year Type of Surgery	Year Type of Surgery
____ Heart Surgery	____ Colon Surgery	____ Small Bowel	____ Hernia Repair
____ Appendectomy	____ Hysterectomy	____ Lung Surgery	____ Tonsillectomy
____ Ulcer	____ Mastectomy	____ Breast Biopsy	____ Gallbladder Removal
____ Lumpectomy/Axillary dissection	____ NO SURGERIES		

Other: _____

_____

HOSPITALIZATION

Please list any recent illnesses or hospitalizations and conditions: _____

_____

_____

BREAST HISTORY II

Date of last Mammogram: _____

Do you have yearly mammograms: ☐ Yes ☐ No

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

Have you had a breast ultrasound? ☐ Yes ☐ No

Do you perform monthly breast exams? ☐ Yes ☐ No

Have you had a breast biopsy? ☐ Yes ☐ No

Have you been diagnosed with breast cancer? ☐ Yes ☐ No

If yes, when? _____ what type? _____

Was surgery performed ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Radiation ☐ Yes ☐ No

Have you had a previous breast augmentation? ☐ Yes ☐ No

Have you ever been instructed on how to perform a self-breast exam? ☐ Yes ☐ No

Breast biopsy result: _____

FAMILY HISTORY

Does anyone in your family have any of the following? If yes, give relationship

Relation	Diabetes	Hypertension	Heart Disease	Stroke	Bleeding Disorder	Seizure Disorder	Cancer	Type of Cancer
Mother	_____	_____	_____	_____	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____	_____	_____	_____
Daughter	_____	_____	_____	_____	_____	_____	_____	_____
Son	_____	_____	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____	_____

Other _____

SOCIAL HISTORY

Tobacco Use: ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker ☐ Chain-Smoker

☐ Heavy Smoker (20-39/day) ☐ Moderate (10-19/day) ☐ Light (1-9/day)

IV drug use: ☐ No ☐ Yes, explain _____

Use of alcohol: Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If yes, how often: ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week

Caffeine: ☐ coffee/tea _____ per day ☐ soft drinks _____ per day

Marital status: ☐ married ☐ single ☐ divorced ☐ widowed

REVIEW OF SYSTEMS

Are you experiencing any of the following:

CONSTITUTIONAL SYMPTOMS		
Fever	Yes	No
Fatigue	Yes	No
Recent Weight change	Yes	No
Insomnia	Yes	No

EYES		
Wear glasses/contacts	Yes	No
Eye vision problems	Yes	No

EARS, NOSE, MOUTH, THROAT		
Hearing loss/ringing	Yes	No
Ear aches	Yes	No
Nose bleeds	Yes	No
Sinus problems	Yes	No
Frequent colds	Yes	No
Dental problems	Yes	No
Sore throat/hoarseness	Yes	No
Swollen glands	Yes	No

HEART		
Chest pain/heart attack	Yes	No
Irregular/fast heartbeat	Yes	No
Swelling feet/ankles	Yes	No

LUNGS		
Shortness of breath	Yes	No
Cough	Yes	No
Spitting up blood	Yes	No
Asthma/wheezing	Yes	No

GASTROINTESTINAL		
Loss of appetite	Yes	No
Nausea/Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Change in bowel habits	Yes	No

GENITOURINARY		
Frequent urination	Yes	No
Painful/burning urination	Yes	No
Bladder control problems	Yes	No
Kidney stones	Yes	No
Venereal disease	Yes	No

MUSCULOSKELETAL		
Joint pain/swelling	Yes	No
Muscle/joint weakness	Yes	No
Back pain	Yes	No
Cold extremities	Yes	No
Numbness/tingling	Yes	No
Varicose veins	Yes	No
Phlebitis	Yes	No

BREAST/SKIN		
Breast pain	Yes	No
Breast lump	Yes	No
Nipple discharge	Yes	No
History of breast cancer	Yes	No
Rash/itching	Yes	No
Change in skin/hair	Yes	No

NEUROLOGIC		
Frequent headaches	Yes	No
Light headed/dizzy	Yes	No
Tremors	Yes	No
Paralysis/Stroke	Yes	No

PSYCHIATRIC		
Memory loss/confusion	Yes	No
Depression	Yes	No

ENDOCRINE		
Hormonal problems	Yes	No
Excessive thirst	Yes	No
Excessive urination	Yes	No
Intolerance cold/hot	Yes	No

HEMATOLOGICAL/LYMPHATIC		
Bleeding/bruising	Yes	No
Slow to heal	Yes	No
Anemia	Yes	No
Swollen lymph nodes	Yes	No

ALLERGIC/IMMUNOLOGICAL		
Seasonal allergies	Yes	No
Frequent infections	Yes	No

Signature _____