THE Breast CENTER
Specialists In Breast Care

Chart #

Office Use Only

PATIENT INFORMATION			
Last Name	First Name		Middle Initial
Your Name as it appears on your insurance card			
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Best place and time to contact you:	Can we leave a message at home: ☐Y or ☐N Can we leave a message at work: ☐Y or ☐N		
SSN	Date of Birth	☐ Male ☐ Female	Marital Status
Race	Ethinicity		Preferred Language
Employer Name and Address	Email		
Primary Care Physician *(name and phone number)* Referring? Yes / No	OB/GYN *(name and phone number)* Referring? Yes / No		
Emergency Contact	Emergency Contact's Phone #	Relationship to Emergency Contact	

Insurance Policy Holder (Sponsor's Information, leave blank if same as above)			
Last Name	First Name		Middle Initial
SS #	Date of Birth	☐ Male ☐ Female	Relationship to insured
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Employer Name and Address			

Insurance Information		
Primary Insurance Company	Policy Number	Group Number
Secondary Insurance Company	Policy Number	Group Number

When checking in, the receptionist will need your insurance card(s), a picture ID, and your co-pay amount.

We will file insurance with your provider according to your individual plan.

Our fees will vary depending on the complexity of your problem and the service provided. We will be glad to discuss our fees with you at any time. If payment of charges imposes a financial burden, we ask that you speak to our billing office for specific payment arrangements prior to your appointment. We will make every effort to assist you with your needs.

Patient / Guardian Signature

Date