Kelly R. Kunkel, M.D., P.A.

Patient Information

Name: _____
(first) (middle) (last)

Date of birth: _____ Age: _____ Last 4 digits of SS#: _____ Married/Single/Divorced/Widowed

Address: Street: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

How did you find out about our office? _____

Employer (If the patient is a minor, list the guardian's employer): _____

Employer's address: _____

Emergency Contact: _____

RESPONSIBLE PARTY (PRIMARY INSURED)

Insurance Company: _____ Name of

Insured: _____ Date of birth: _____

Address of Insured: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

SECONDARY INSURANCE

Insurance Company: _____ Name of

Insured: _____ Date of birth: _____

Social Security #: _____

Privacy in communication is important. Please help us understand your communication wishes:

Communication by texting and email is convenient, efficient, and a part of daily life for many people. It is important that you understand that email and text communications between you and us are not encrypted and therefore not secure. If you communicate with us from your workplace computer, your employer and its agents may have access to these communications. Any email communication between you and us may become part of your medical record and be accessible to the office staff as needed. Please place check marks to indicate your preferences:

___Yes, I consent to texting communication with Dr. Kunkel and the office staff

___List your email address if you authorize Dr. Kunkel and the office staff to communicate with you by email:

_____

___I understand that I am responsible for providing Dr. Kunkel's office staff of any updates to my email address

___I understand that I may revise or withdraw my consent at any time by notifying the office of this desired change

___No, I would prefer not to have email communication

___No, I would prefer not to have text communication

We use an electronic medical record system in the office. To allow more effective coordination of your care with others involved in your care (doctors, hospitals, labs, pharmacies, radiology centers, etc.), the electronic record system may be connected to a secure health information exchange. Please place a check mark to indicate your preference:

___I agree to allow my records to be communicated via the internet health information exchange to aid in coordinating my care.

___I do not want my records to be communicated via the internet health information exchange. I understand this decision means that information that is important to my care may not be communicated as efficiently.

We also utilize TouchMD in the office. TouchMD is an internet-based company that helps us create a more thorough, complete educational experience. By creating a private, password-protected account with TouchMD, you can access diagrams and videos of procedures that are of interest to you. Photographs that we take of you are sent electronically to TouchMD, which then allows you to view the photos in the comfort of your own home or on your mobile device. Please indicate your preference:

___I agree to use the TouchMD service, allowing me to view diagrams, videos, and my photographs through a password-protected internet connection created by TouchMD.

___I do not want to participate in the use of the TouchMD service. I do not wish to see additional videos or diagrams or my photographs through this system.

INSURANCE AUTHORIZATION

I hereby authorize Kelly R. Kunkel, M.D., P.A., and authorized office personnel to furnish information to insurance carriers concerning my health and treatment and I hereby assign Kelly R. Kunkel, M.D., P.A. all payments for services rendered to my dependents or myself. I understand that I am responsible for any charges incurred regardless of insurance coverage.

SIGNATURE: _____ **DATE:** _____

Breast Patient Health Information

Please list other physicians involved in your care:

Primary care physician: _____ Breast surgeon: _____

Ob-gyn physician: _____ Medical oncologist: _____

Other: _____ Radiation oncologist: _____

What is the reason for your visit today? _____

Have you seen another physician related to this concern? If so, who and when? What was done at that time?

_____

Have you noticed significant differences between your breasts? For instance, have you noticed that one breast is larger than the other?
If you have noticed a difference, please describe: _____

Tell us what you would like to accomplish with breast surgery: _____

Have you had surgery (including breast biopsies) on your breasts before? Yes No

If so, please list approximate dates of surgery as well as what was done and which surgeon performed the surgery:

operation #1: date: _____ procedure: _____ surgeon: _____

operation #2: date: _____ procedure: _____ surgeon: _____

Have you undergone radiation therapy to your chest or breast? Yes No If yes, when? _____

Has anyone in your family had problems with her (or his) breasts? Has anyone in your family had breast cancer? Please list:

_____

Have you had a mammogram before? Yes No

If yes, when was your last mammogram, and where was it performed? _____

What were the findings of the mammogram? _____

While the majority of patients who see Dr. Kunkel concerning their breasts are women, some men also have concerns.
The questions in this box are intended for female patients.

Do you know what size bra you wear? Please list, or give an approximation:_____

Please list the year of birth of any children you have delivered: _____ _____ _____ _____ _____

Did you breast feed any of your children? ___Yes ___No ___Tried but was not successful ___Not applicable

If you breast-fed a child who is currently younger than 2, how long ago did you stop breast feeding? _____

Are you currently breast feeding? ___Yes ___No

Do you currently have a discharge from either nipple? ___Yes ___No If yes, which nipple? _____

What is your approximate height? _____feet _____inches What is your approximate weight? _____lbs.

Is your weight more or less stable, or have you lost (or gained) more than 20 pounds over the last year? _____

Are you allergic to anything? __No __Yes If yes, what? _____

Are you currently using a nicotine product like cigarettes, cigars, or e-cigarettes? Yes No

Have you ever used nicotine products like cigarettes, cigars, or e-cigarettes? Yes No

If yes, please tell us about what you have used and for how long: _____

Please list medications, vitamins and herbal supplements that you take:

Name	Dose	How Often

Check any illnesses or conditions YOU have had:

[ ] Diabetes [ ] High blood pressure

[ ] Mitral valve prolapse [ ] Heart problems

[ ] Asthma [ ] Other lung problem

[ ] Hepatitis/jaundice/liver problem

[ ] Bleeding disorder [ ] Blood clots

[ ] Fibromyalgia [ ] Autoimmune problem

[ ] Gastric reflux [ ] HIV

[ ] Stroke/seizure [ ] Kidney problem

[ ] cancer (list): _____

[ ] other medical issues: _____

Please check any operations you have had, and list the approximate year:

[ ] Cesarean section _____ _____ _____ [ ] Hysterectomy _____ [ ] Tubal ligation _____

[ ] Surgery on ovaries _____ [ ] Thyroid surgery _____ [ ] Tonsillectomy _____

[ ] Hernia repair _____ [ ] Appendectomy _____ [ ] Gallbladder _____

[ ] Surgery of the heart or chest _____ [ ] Abdominoplasty _____ [ ] Liposuction _____

[ ] Other surgery (list) _____