Dear ___________________,

Thank you for choosing our office for your surgical consultation. To assist us in providing you with the best care possible, please bring the following with you to your appointment:

- Insurance card(s) and Photo ID
- Any Imaging and coinciding reports (i.e. Mammogram, Ultrasound, CT Scans)
- Pathology reports
- Medication list including dosages
- Complete the forms that are attached in this packet

We value your time and we want to provide you with a comprehensive and in-depth evaluation. To do so, please allow up to two hours in our office for your appointment.

For more information we can also be found online at www.aaronmd.com and on Facebook. If you have any questions prior to your scheduled appointment, please contact our office at 865-692-1610.

Thank you for entrusting us with your surgical care. We look forward to meeting you and providing you with compassionate surgical care that you can trust.

Sincerely,

Aaron G. Margulies, MD, FACS
Breast Surgical Oncologist / General Surgeon
Patient Demographic & Consent Form

First Name: _________________________ Middle Initial _____ Last Name: _______________________________

DOB: _______/_______/_______      SS#:    _______-

Address: _________________________________ City: ____________________ State: _______ Zip Code: ___________

Phone Numbers

Home: (_____) ________________________________
Mobile: (_____) ______________________________
Work: (_____) ________________________________

Preferred Method of Contact: (Circle One)

Home     Mobile     Work     E-Mail

Marital Status: ________________

Email: ____________________________@______________

Emergency Contacts

1. _________________________________ Relation: _____________ Phone: __________________________________
2. _________________________________ Relation: _____________ Phone: __________________________________

Do you consent for our office to leave a voice message if needed?      Yes      No

May we contact and share medical information with your emergency contacts if needed?      Yes      No

Would you like an email for sign-up information to Dr. Margulies’ blog on Breast Cancer?      Yes      No

Would you like an email invite to register an account on our patient portal?      Yes      No

Which Office is most convenient for you? (Circle One)  North Knoxville  West Knoxville  Jefferson City  Morristown

How did you hear about us? ___________________________________________________________________________

If you are a Breast Care Patient, do you give consent for Dr. Margulies to discuss your case with other physicians?    Yes    No

If you are a Genetics Patient, do you give consent for our office to release or obtain copies of your genetic testing?  Yes    No

Insurance *If your insurance carrier through your spouse or someone else please complete the following:

Name of Insured: ___________________________________   DOB:  ______________        SS#:    _______

Treating Physicians:

Primary Care Physician: _____________________ Referring Physician: ________________________________

Medical Oncologist: _____________________ Radiation Oncologist: ________________________________

Gynecologists: ______________________

Pharmacy:   Name: ________________________________ City: ______________ Phone: ______________________

By signing below, I verify that all the information above is correct. I also verify that I have been offered and have reviewed a copy of the Patient Privacy Notice required by HIPAA and understand my right to privacy as a medical patient of Aaron G. Margulies MD, PLLC.

Patient / Responsible Party Signature: __________________________________________ Date: ___________________
FINANCIAL RESPONSIBILITY FORM

At the office of Aaron G. Margulies, MD, PLLC, we strive to give you the best possible care. In order to serve this purpose, it is important that our patients understand the process of reimbursement. Please read this Financial Responsibility Form and sign to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier.

We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payment due will be yours.

*If you have any changes in your insurance coverage you must notify us prior to your appointment.

DEDUCTIBLES, COINSURANCE AND COPAYMENTS

The deductible is determined by your individual contract with your insurance carrier. You are responsible for your deductibles, copayments, and coinsurance. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay deductibles, coinsurance and copayments, when this applies.

NON-COVERED SERVICES AND MEDICAL NECESSITY

All patients are responsible for account balances if their insurance carrier denies payment for services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary.” To avoid this, please check with your insurance carrier prior to receiving any treatment or services.

By signing below, I authorize the release of any medical information necessary to process insurance claims filed to my insurance carrier on my behalf or on the behalf of my dependents. I authorize payment for medical benefits to be made directly to my physician for services rendered at the office of Aaron G. Margulies, MD, PLLC.

I certify that I have read the above disclosure statements, understand my responsibilities, and agree to the terms written above.

Patient / Responsible Party Signature _____________________________ Date _________

Patient / Responsible Party Name (Please Print) _____________________________

Relation to Patient: _______________________________________________________

Breast Intake Form – Medical History

Name: _________________________________ DOB: ______________

Reason for Visit: (give a brief description):

Date of Last Mammogram: 
Location:

Medical History / Problems:

Past Surgeries:

Daily Medications & Supplements:

Medication Allergies:

Social History

Employment Status:

Tobacco Use:
(If yes, how much per day?) _________________________________

YES NO

Alcohol Use:

Any Family History of Bleeding Disorders?

Have any family members been instructed to never have anesthesia?

YES NO

Risk Calculations

Ashkenazi Jewish Heritage?

Weight: 
Height: 
Bra Size:

Number of Pregnancies: 
Number of live Births: 
Age of First Live Birth:

Age of First Menses: 
Date of Last Menstrual Cycle:

Do you still have your ovaries:
(If no, what age were they removed?)

YES NO

Hysterectomy:

YES NO

Oral Contraceptive Use:
(If yes, how many years and when did you discontinue use?)

YES NO

Hormone Replacement:
(If yes, what kind and how many years did you take this?)

YES NO

Previous History of any Breast Biopsies:
(If yes, have you ever had Atypia, ADH, of LCIS?)

YES NO

Do you have any personal or family history of the following types of cancer? If so, check the appropriate box.

- Breast
- Ovarian
- Uterine
- Pancreatic
- Prostate
- Colon
Name: ________________________________ DOB: ______________________ MRN: ________
How many sisters do you have? _____  How many brothers? _____
How many children do you have? _____  Daughters_____ Sons _____
How many sisters does your mother have? ______  How many brothers? _____
How many sisters does your father have? _____  How many brothers? _____
Ethnic background: _________________________________  Ashkenazi Jewish?  Y/N

*PLEASE LIST ALL MEMBERS OF YOUR FAMILY ALIVE OR DECEASED*
*Indicate who (including yourself) has had Cancer - (Especially breast, ovarian, pancreatic, prostate)*

<table>
<thead>
<tr>
<th>RELATIVE</th>
<th>First Name</th>
<th>Alive (Age)</th>
<th>Deceased (Age)</th>
<th>Cancer – Y/N</th>
<th>Type</th>
<th>AGE at DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Side</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father’s Side</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you have a large family history of cancer, please list on the back of this sheet additional family members (cousins, etc.) that may provide more accurate information regarding your family history of cancer.**