



Elizabeth Bonefas, M.D., P.A.

General Surgery and Diseases of the Breast

Dear Patient:

Thank you for choosing Elizabeth Bonefas, M.D., for your medical care. In an effort to serve you better and more efficiently, enclosed you will find your appointment card as well as demographic, medical history, and HIPAA forms for you to complete at home and then bring with you to your appointment. Also, please bring your insurance card, co-pay (exact change) and picture identification.

If your insurance requires a referral or authorization from your primary care physician to see a specialist, then it is your responsibility to obtain that referral before you come to your office visit. If you do not have this referral, then you will be rescheduled. You may wish to contact your insurance company directly to verify whether or not you require a referral.

If you are coming in for a breast problem, then it is very important for you to pick up your films and reports prior to your office visit and bring them with you. Please do not rely on the radiology center to send them for you. If you forget your films, we will not be able to perform a thorough examination.

We look forward to seeing you in the office and taking care of your medical needs.

ELIZABETH BONEFAS, M.D., F.A.C.S. AND OFFICE STAFF

6800 West Loop South, Suite 520
Bellaire, Texas 77401
713-756-8555 713-756-8305 fax
www.breasthealthouston.com



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Patient Name: _____ SS# _____ Date of Birth: _____
(Last) (First) (MI)

Address: _____ Sex: M _____ F _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

Email: _____

Pharmacy Preference (Name/address/phone): _____

Referring Physician (Name/Phone): _____

Employer: _____ Phone: () _____

Address: _____ Suite# _____

City: _____ State: _____ Zip: _____

Responsible Party/Guardian Name: _____ Relationship: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Phone: () _____ Date of Birth: _____ SS# _____ Sex: M _____ F _____

Primary Insurance Company Name: _____

Policy Holders Name: _____ Date of Birth _____

Employer: _____ Employer's Phone: () _____

Policy or ID# _____ Group# _____

Insurance Company Address _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company Name: _____

Policy Holders Name: _____ Date of Birth _____

Employer: _____ Employer's Phone: () _____

Policy or ID# _____ Group# _____

Insurance Company Address _____

City: _____ State: _____ Zip: _____

****Emergency Contact**** Name: _____ Relationship: _____

Home Phone: () _____ Cell: () _____ Work: () _____

You are to provide copies of your current Insurance Card(s) & Drivers License or Photo ID. We reserve the right to refuse treatment if these items are not provided. We also reserve the right to refuse treatment to those persons who use vulgarity or threats to staff or physicians.

AUTHORIZATION TO PAY BENEFITS TO FACILITY: I hereby authorize payment directly to Elizabeth Bonefas, MD, PA. Not to exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed private insurance carrier payment, and if greater than such payment, I will be held responsible for that amount.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned provider to release any information required in the course of my examination or treatment to my insurance company or their contracted entities. (If patient is a minor, parent must sign)

Signature: _____ Date: _____



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Health History Form - Please Give To Nurse When Called

Patient Name:				
Today's Date:				
Present Illness (A brief description of your present complaint)				
				Date issue started:
Surgical History (Please Check All That Apply)				
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Parathyroid Surgery	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> D&C	<input type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Abdominal Surgery	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Heart Valve Repair	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Gallbladder Removal
<input type="checkbox"/> Sinus Surgery	<input type="checkbox"/> Abdominal Aortic Aneurism	<input type="checkbox"/> Appendix Removal	<input type="checkbox"/> Tubes Removed	
<input type="checkbox"/> Thyroid Surgery	<input type="checkbox"/> Breast Lumpectomy	<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> No Prior Surgery
<input type="checkbox"/> Other:				
Personal Medical History				
<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> COPD	<input type="checkbox"/> Reflux	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Bladder Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate Disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Pituitary/Hypothalamic	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV
<input type="checkbox"/> Allerg.Rhinitis/Hayfever	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Peripheral Vasc Dis.	<input type="checkbox"/> Adrenal Disorder	<input type="checkbox"/> Easy Bleeding	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disorders	<input type="checkbox"/> Renal Disorders	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Other:				
<input type="checkbox"/> Yes - <input type="checkbox"/> No Have you had a blood transfusion? When? Where? Reaction?				
<input type="checkbox"/> Yes - <input type="checkbox"/> No Previous Hospitalizations				
Previous Tests (Include Date)				
<input type="checkbox"/> EKG:	<input type="checkbox"/> Breathing Tests:	<input type="checkbox"/> Mammogram:	<input type="checkbox"/> Test For Stool Blood:	<input type="checkbox"/> Cholesterol:
<input type="checkbox"/> Chest X-Ray:	<input type="checkbox"/> Blood Tests:	<input type="checkbox"/> Prostate Exam:	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Cardio Stress Test
<input type="checkbox"/> Colonoscopy				
Allergies / Reactions				
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Cephalosporin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Anesthetics
<input type="checkbox"/> Bandaging Tape	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Narcotics	<input type="checkbox"/> Latex
<input type="checkbox"/> Contrast Material - Iodine	<input type="checkbox"/> Yes - <input type="checkbox"/> No Other			
Immunizations (Include Date)				
<input type="checkbox"/> Flu	<input type="checkbox"/> Pneumovax	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Hep B	<input type="checkbox"/> PPD (Tuberculosis Test)
<input type="checkbox"/> DTP	<input type="checkbox"/> Meningococcal			
Marital Status				
<input type="checkbox"/> Single	<input type="checkbox"/> Married, Yrs:	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
Social History (Check All That Apply)				
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Do You Smoke?	<input type="checkbox"/> Caffeine Use	Cups of Tea/ Day: ____	<input type="checkbox"/> Chocolate Intake
Drinks per day: ____	Cigarette packs per day: __	Cups of Coffee/ Day: ____	<input type="checkbox"/> Recreational Drug Use	<input type="checkbox"/> Regular Exercise



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Health History Form - Please Give To Nurse When Called

Patient Name:

Family History										
Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adopted: Family History Unavailable

Women's History

Last Period: ____	Age of first period: ____	<input type="checkbox"/> Regular Cycles	Last Pap Smear: ____	Last Pap Smear: ____
Age at 1 st Delivery ____	Pregnancies (Gravida): ____	Deliveries (Para): ____	Abortions (incl. miscarriages): ____	<input type="checkbox"/> Menopause



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Family History Questionnaire for Hereditary Breast and Ovarian Cancer Syndromes

Patient Name:	Physician:
Date of Birth:	Date Completed:
Are you of Ashkenazi Jewish descent? YES / NO (circle one)	

Please place a check (✓) mark in the boxes below for yourself and family members who have had cancer as indicated.

Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Have you or any family members ever been diagnosed with:	You			Family Members			
	No	Yes	Age of diagnosis	No	Yes**	Mother's side (✓)	Father's side (✓)
Breast cancer?							
Two or more breast cancers (bilateral or contralateral)?							
Ovarian cancer?							
Male breast cancer?							

List any other cancers in you or your family:

** List all relatives (relation, not name) diagnosed with the above cancers along with age of diagnosis:

If you checked yes in one or more boxes on the Family History Questionnaire ask your doctor to assess your cancer history. If your history indicates that you may have an inherited risk of cancer, there is a blood test that can help determine if you are at risk for hereditary cancer.

Please talk to your doctor about reducing your risk and possibly preventing cancer.

P-1: Notice of Privacy Practices

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.

Uses and Disclosures of Treatment, Payment and Healthcare Operations (TPO) Information

1. Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
2. Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
3. Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of **Elizabeth Bonefas, MD, PA**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
4. Law enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
5. Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Non- TPO Information:

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

1. Appointment reminders: Your health information will be used by our staff to send you appointment reminders.
2. Information about treatments: Your health information may be used to send you information on the treatment and management of your condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

Please do not use my information for fund raising purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Elizabeth Bonefas, MD, PA

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. 'Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Frances Schock, Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Frances Schock
Elizabeth Bonefas, M.D., P.A.
6800 West Loop South, Suite 520
Bellaire Tx 77401

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

**Frances Schock, Privacy Officer
Elizabeth Bonefas, M.D., P.A.
6800 West Loop South, Suite 520
Bellaire TX 77401
713-756-8555**

Effective Date

This Notice is effective on or after April 15, 2003.

Patient Acknowledgement:

I have received and read the Privacy Notice given to me by the above named Practice. I understand that the disclosure of my protected health information (PHI) will be according to the HIPAA guidelines, as described above.

Name of the Patient

Signature of Patient/Legal Representative

Date
