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

Address:_____ **Sex: M**_____ **F**_____

City:_____ **State:**_____ **Zip:**_____

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

Email: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____

Primary Language:

- English
- Spanish
- Other:_____
- Unreported/Refused

Race:

- White
- Black / African-American
- Asian
- American Indian/Alaskan Native
- Other: _____
- Unreported/Refused

Are You:

- Hispanic/Latino
- Not Hispanic/Latino
- Other_____
- Unreported/Refused

Pharmacy Preference (Name/Zip Code/phone):_____

Referring Physician (Name/Phone):_____

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:**_____

Elizabeth Bonefas, M.D., F.A.C.S.
General Surgery and Diseases of the Breast

****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.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA branch of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings: (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient name (please print) Patient DOB

_____ _____

Patient Signature

_____

Date

_____

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

Symptoms Being Experienced By Patient *Today* · Please Give To Nurse When Called

Name: **Today's Date:**

Present Illness (A brief description of your present complaint)

Date issue started:

Review Of Current Symptoms · Check All That Apply

☐ Tired / Feeling Poorly	☐ Ear Drainage	☐ Chest Pain/Discomfort	☐ Blood In Stool	☐ Intolerance to Cold
☐ Wt Loss	☐ Dizziness	☐ Palpitations	☐ Bloating	☐ Excessive Thirst
☐ Wt Gain	☐ Nosebleeds	☐ Lightheadedness	☐ Pain During Urination	☐ Constant Hunger
☐ Appetite Decreased	☐ Nasal Congestion	☐ Ankle Swelling	☐ Urinary Frequency	☐ Night Sweats
☐ Appetite Increased	☐ Snoring	☐ Difficulty Breathing	☐ Bloody Urine	☐ Headache
☐ Fever	☐ Post Nasal Drip	☐ Shortness Of Breath	☐ Burning w/ Urination	☐ Tremors
☐ Chills	☐ Hoarseness	☐ Wheezing	☐ Urinary Loss of Control	☐ Memory Lapses
☐ Numbness	☐ Difficulty Swallowing	☐ Cough	☐ Skin Rash	☐ Fainting
☐ Worsening Vision	☐ Sore Throat	☐ Sneezing	☐ Muscle Weakness	☐ Tingling
☐ Eye Pain	☐ Heart Burn	☐ Breast Pain	☐ Muscle Aches	☐ Difficulty Walking
☐ Seeing Double	☐ Tooth Pain	☐ Breast Lump	☐ Joint Pain	☐ Depression
☐ Eyes Itch	☐ Mouth Dryness	☐ Abdominal Pain	☐ Joint Swelling	☐ Anxiety
☐ Red Eyes	☐ Jaw Pain	☐ Nausea	☐ Back Pain	☐ Sleep Disturbances
☐ Loss Of Hearing	☐ Loose Teeth	☐ Vomiting	☐ Easy Bleeding	☐ Insomnia
☐ Earache	☐ Swollen Neck Glands	☐ Diarrhea	☐ Easy Bruising	☐ Sleep Apnea (Periods)
☐ Ringing In The Ears	☐ Neck Pain	☐ Constipation	☐ Intolerance to Heat	

Current Medications

Name	Dose	Frequency

Revised: 8.2.2007

Elizabeth Bonefas, M.D., P.A.
General Surgery and Diseases of the Breast

Health History Form

Patient Name:	**Today's Date:**

Allergies / Type of Reactions

☐ Penicillin	☐ Cephalosporin	☐ Tetracycline	☐ NSAIDS	☐ Anesthetics
☐ Bandaging Tape	☐ Sulfa Drugs	☐ Aspirin	☐ Narcotics	☐ Latex
☐ Contrast Material - Iodine	☐Yes - ☐No Other			
For all that is checked, please explain reaction.				

Women's History

Last Period: _____	Age of first period: _____	☐ Regular Cycles	Last Pap Smear: ____	Last Pap Smear: ____
Age at 1st Delivery____	Pregnancies (Gravida): ___	Deliveries (Para): _____	Abortions (incl. miscarriages): _____	☐ Menopause

Medical History (Include Date)

☐ Headache/Migraine	☐ COPD	☐ Reflux	☐ Kidney Stones	☐ Anxiety
☐ Epilepsy	☐ Pneumonia	☐ Peptic Ulcer	☐ Bladder Disorder	☐ Depression
☐ Glaucoma	☐ Tuberculosis	☐ Hepatitis	☐ Prostate Disorder	☐ Cancer
☐ Pituitary/Hypothalmic	☐ Sleep Apnea	☐ Gallstones	☐ Venereal Disease	☐ HIV
☐ Allerg.Rhinitis/Hayfever	☐ Hypertension	☐ Pancreatitis	☐ Arthritis	☐ Hyperlipidemia
☐ Chronic Sinusitis	☐ Angina (Chest Pain)	☐ Diabetes Mellitus	☐ Osteoporosis	☐ Blood transfusion
☐ Thyroid Disorders	☐ Peripheral Vasc Dis.	☐ Adrenal Disorder	☐ Easy Bleeding	
☐ Asthma	☐ Heart Disorders	☐ Renal Disorders	☐ Anemia	
☐ Other:				

Surgical History (Please Check And Date All That Apply)

☐ Eye Surgery	☐ Parathyroid Surgery	☐ Mastectomy	☐ D&C	☐ Orthopedic Surgery
☐ Adenoidectomy	☐ Heart Surgery	☐ Abdominal Surgery	☐ Cesarean Section	☐ Spinal Surgery
☐ Tonsillectomy	☐ Heart Valve Repair	☐ Hernia Repair	☐ Tubal Ligation	☐ Gallbladder Removal
☐ Sinus Surgery	☐ Abdominal Aortic Aneurism	☐ Appendix Removal	☐ Tubes Removed	
☐ Thyroid Surgery	☐ Breast Lumpectomy	☐ Breast Biopsy	☐ Hysterectomy	☐ **No Prior Surgery**
☐ Other:				

Social History (Check All That Apply)

☐ Single	☐ Married, Yrs:	☐ Separated	☐ Widowed	☐ Divorced
☐ Alcohol Use	☐ Do You Smoke?	☐ Caffeine Use	Cups of Tea/ Day: ____	☐ Chocolate Intake
Drinks per day: ____	Cigarette packs per day: __	Cups of Coffee/ Day: ____	☐ Recreational Drug Use	☐ Regular Exercise

Previous Tests (Include Date)

☐ EKG:	☐ Breathing Tests:	☐ Mammogram:	☐ Test For Stool Blood:	☐ Cholesterol:
☐ Chest X-Ray:	☐ Blood Tests:	☐ Prostate Exam:	☐ Echocardiogram	☐ Cardio Stress Test
☐ Colonoscopy				

Patient Name:	**Today's Date:**

Family History										
Condition	**Father**	**Mother**	**Brothers**	**Sisters**	**Sons**	**Daughters**	**Maternal Grand Mother**	**Maternal Grand Father**	**Paternal Grand Mother**	**Paternal Grand Father**
Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Other**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Adopted: Family History Unavailable**										

Family History: Hereditary Breast and Ovarian Cancer Syndromes

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.

Revised: 3.21.2018

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 ser vice, 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 writ ten 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 service that we believe may interest you.

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

Elizabeth Bonefas, M.D., F.A.C.S.
General Surgery and Diseases of the Breast
Telephone: 713-756-8555 Fax: 713-756-8305
www.breasthealthhouston.com

PHYSICIAN OWNERSHIP DISCLOSURE FORM

To: New Patients on Date of First Visit with Elizabeth Bonefas, M.D.

During the course of your physician/patient relationship with, Elizabeth Bonefas, M.D. may refer you to St. Joseph Medical Center, Memorial Houston Surgical Center, or St Joseph Cancer Center, (the "Facility").

In connection with any referral to the Facility, you are hereby advised that Elizabeth Bonefas, M.D. has an investment interest in the Facility and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you at the time of Elizabeth Bonefas, M.D. 's first contact with you as a patient and will also be provided to you at the time of referral, if any, to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician, the physician's staff, or the Facility if you choose to use a different facility.

Should Elizabeth Bonefas, M.D. at any time refer you to the Facility and you prefer to use a different health care provider, you will be advised of alternative health care providers and your right to choose one of these alternative health care providers.

_____
Patient name (please print)

_____
Patient signature

_____
Date