Susan C.Gaskill, M.D.

PATIENT INFORMATION RECORD

Today's Date:____
Date of Appt:______________________ Time:____________

Patient Name: **Last, First, MI**____
Date of Birth:________________________________ SS#_________________________________
Marriage Status:_________________ **Female / Male** Ethnicity:______________________
Home Phone:______________________ Work Phone:__________________ Cell:________________
Address:____
Email Address:____
Employer:____
Address:____

Appt type:___________________________ Reason for Exam:_______________________________

History of Breast Surgery: Mastecomy Reduction
Lumpectomy (Cancer) Implants
Biopsy (Benign) Biopsy (LCIS/Atypia)

Date of Last Exam:______________________ Facility Name:________________________________
(**Fill out request to obtain medical records form**)

Breast Feeding/Pregnant yes / no
Notes:____

Referring Physician:____
Office Number:_________________________
(**Order required that matches appt type if not a self-referral**)

2nd Physician:____
Office Number:_________________________

Primary Insurance Carrier:____
Patient Account #________________________ Group #_______________________
Address:____
Benefit/Pre Cert #________________________ Verification #:__________________
Subscriber:___________________________ Relation to Patient:_________________
Subscriber SS #_______________________ Subscriber DOB:__________________
Subscriber's Employer:____

Secondary Insurance Carrier:____
Patient Account #________________________ Group #________________________
Address:____
Benefit/Pre Cert #_________________________Verification #___________________
Subscriber:___________________________ Relation to Patient:__________________
Subscriber SS #:_______________________ Subscriber DOB:___________________
Subscriber Employer:____

Emergency Contact Person:____
Home Phone:______________ Work Phone:______________ Cell:_______________
How did you hear about us:____