



JULIANN REILAND-SMITH, M.D., FACS
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NEW PATIENT INFORMATION

Patient's Name: _____ Social Security Number: _____
 (First) (Middle Initial) (Last)

Address: _____
 (Street) (City) (State) (Zip)

Date of Birth: ____ / ____ / ____ Age: ____ Sex: ____ Marital Status: ____

Home Phone: _____ Cell Phone: _____ Leave Medical Message on Voice Mail: Yes No

Email Address: _____

Occupation: _____ Employer: _____ Business Phone: _____

Employer Address: _____
 (Street) (City) (State) (Zip)

Who to contact in case of emergency:

Name: _____ Address: _____ Phone: _____

Insurance Policy Holder: _____ Policy Holders Date of Birth: ____ / ____ / ____

In general, your health information cannot be shared unless you give your permission. Please list persons authorized to access your medical information.

Name	Relationship	Phone
_____	_____	_____

Authorization for Treatment: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic and medical treatment by my physician, her assistants, or her designees including consulting physicians, employees, and students in educational programs affiliated with Comprehensive Breast Care, PC, as is necessary in the judgment of my physician. I consent to testing for HIV (AIDS) and or Hepatitis should a health care worker have accidentally been exposed to my blood or other body substances. _____ (Patient Initial)

Release of Information: I hereby authorize Comprehensive Breast Care, PC to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to third party payers and/or their reviewing contractors to comply with preadmissions review and continued stay requirements. I authorize the release of clinic information to all referring physicians and facilities for the purpose of continued care. _____ (Patient Initial)

Assignment of Benefits: Authorization is hereby granted for the direct payment to Comprehensive Breast Care, PC for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage. _____ (Patient Initial)

Acknowledgement of Receipt of Privacy Policy Notice: I acknowledge the understanding of Comprehensive Breast Care, PC "Notice of Private Practices" (HIPPA). _____ (Patient Initial)

 Patient Signature

 Patient Representative

 Date

 Relationship to Patient

Photo Release: I hereby give Comprehensive Breast Care, PC the absolute and irrevocable right to take and permission to use/reuse photographs of me for my care, medical information of the public, and medical staff of clinic employees. I hereby release and discharge Comprehensive Breast Care, PC from any and all claims and demands arising out of or in conjunction with the use of the photographs, including but not limited to any and all claims of libel, invasion of privacy, etc.

 Patient Signature

 Date