Marie F. Pennanen, M.D., F.A.C.S.
Director, Chevy Chase Breast Center
5530 Wisconsin Avenue, Suite 1455
Chevy Chase, MD 20815
Phone: 301-656-9010 Fax: 301-656-9011

Diplomate, American Board of Surgery
Clinical Associate Professor of Surgery,
Georgetown University Medical School
Member, American Society of Breast Surgeons

Name: _____ Date: _____

Date of Birth: _____

I prefer to be called: _____

I currently have (circle): ◊ No breast problems ◊ Breast pain ◊ Breast lump or mass
◊ Nipple discharge ◊ Breast skin changes ◊ Abnormal Mammogram ◊ Abnormal Breast MRI
◊ Family history of breast cancer ◊ History of breast cancer ◊ Other: _____

I have had a previous:

Breast biopsy (circle): Yes No If yes, list year(s) and results: _____
Cyst aspiration (circle): Yes No If yes, list year(s): _____
Breast infection (mastitis) or abscess (circle): Yes No
Breast reduction: Yes No Breast implants: Yes No
Other breast surgery: _____ Radiation Exposure: Yes No

Have you had genetic testing: Yes No If yes: date tested _____ Which company: _____

Gynecologic History: Age with first period: _____ First day of most recent menstrual period: _____
Number of pregnancies: _____ Number of live births: _____ Age with first live birth: _____
Breast fed: Yes No Duration with each child: _____ Age with menopause: _____
Hormone use (circle): birth control pills hormone replacement therapy fertility medication
Type: _____ Number of years of use: _____
Were you exposed to DES (diethylstilbestrol) in utero? Yes No Have you ever taken DES? Yes No

Height: _____ Weight: _____ Bra size: _____

Cigarette smoking: _____ packs per day for _____ years Quit (date): _____ Alcohol: _____drinks/day
Exercise frequency: _____ times per week Diet (circle one): High fat Medium Low fat

Have you ever had your vitamin D level checked? _____ If yes, list year of last study/result: _____
Have you had a colonoscopy? Yes No If yes, list year of last study/result: _____
Have you had a DEXA scan (bone density study)? _____ If yes, list year of last study/result: _____
Date of last gynecologic examination: _____
Caffeine (coffee, tea, cola, chocolate): _____ Amount Per Day: _____
Occupation: _____ Date of last COVID-19 vaccination: _____

In which arm did you receive your last COVID-19 vaccination?
Right or Left

I have the following medical problems (circle):

Hypertension	Heart Disease	Heart murmur	Stroke	Irregular heartbeat	High cholesterol	
Diabetes	Thyroid disease	Asthma	COPD	Sinus problems	GERD (reflux)	Peptic ulcers
Crohn's Disease	Celiac Disease	Chronic Ulcerative Colitis		Osteoporosis	Arthritis	Psoriasis
Venus thrombosis (blood clot)		Pulmonary embolism		Coagulopathy (clotting disorder)		
Cancer: _____		Kidney failure/insufficiency		Bleeding Diathesis (bleeding tendency)		
Seizures	Depression	Other psychiatric diagnosis		Cataracts	Glaucoma	Hearing Loss
Uterine fibroids	Other: _____					

List any surgery you have had and the year(s) it was performed: _____

_____

Have you had any problems with anesthesia? If yes, please explain: _____

Do you have a history of high temperature, muscle spasms, or dark urine immediately after anesthesia or serious exercise? _____

Medications/vitamins/supplements: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

6. _____ 7. _____ 8. _____

Alternative or Complementary medical therapy or herbal remedies: _____

Do you take aspirin on a daily basis? Yes No

Medication allergies: ◊ I have no medication allergies

1. _____ Reaction: _____

2. _____ Reaction: _____

Environmental allergies: ◊ I have no environmental allergies

1. _____ Reaction: _____

2. _____ Reaction: _____

Are you allergic to Latex? Yes No Are you allergic to adhesive/tape? Yes No

I currently have the following symptoms: ◊ I have none of the physical symptoms listed below

fever	chills	fatigue	weight loss _____ (amount)	weight gain _____ (amount)	
chest pain	palpitations	cough	shortness of breath: ◊ at rest	◊ with activity	
sinus pain	seasonal allergies/ hay fever		abdominal pain	loss of appetite	nausea
vomiting	constipation	diarrhea	bloody stool	abdominal bloating	skin rashes
pain with urination	frequent urination		incontinence	vaginal spotting	vaginal discharge
bone pain	leg swelling		headaches	hot flashes	vaginal dryness
joint pain	weakness of arm or leg		dizziness	ringing in ears	numbness/tingling
back pain	blurred vision		bloody nose	mouth ulcers	dental problems
neck pain	impaired vision		Other: _____		

Family history of cancer:

The presence of an abnormal gene (BRCA 1 or 2) which strongly increases one's risk for breast cancer is found more commonly in people of certain ethnic backgrounds.

Please circle all that apply to you. Please write *P for Paternal* and *M for Maternal* next to any circled:

Ashkenazi	Western/Northern European	Central/Eastern European	African	Asian
American/Caribbean	Near/Middle Eastern	Native American	Latin	

Please check all the boxes that apply to your family members and note the age of the cancer diagnosis.

Relative	Breast cancer/Age when diagnosed		Ovarian Cancer/Age	Uterine Cancer/ Age	Colon Cancer/ Age	Prostate Cancer/ Age	Other Cancer/ Age
	One breast	Both breasts					
Mother							
Daughter							
Sister							
Sister							
Sister							
Mat. Grandmother							
Maternal Aunt							
Maternal Aunt							
Maternal Aunt							
Pat. Grandmother							
Paternal Aunt							
Paternal Aunt							
Paternal Aunt							
Father							
Brother							
Brother							
Brother							
Mat. Grandfather							
Maternal Uncle							
Maternal Uncle							
Pat. Grandfather							
Paternal Uncle							
Paternal Uncle							
Maternal cousin							
Paternal cousin							
Other relatives:							

I have filled out these forms to the best of my knowledge: _____ (patient signature)

I have reviewed all 3 pages of this patient's medical history: _____ Marie F. Pennanen, MD

Lori C. Zorc, EdD, ANP-BC

Chevy Chase Breast Center

Name: _____ Referring Physician: _____

- Please list below the physician(s) who care for you. If you are unsure of their phone number or address, please list any information that would help us locate the individual.
- I typically send a copy of my office visit note to each physician listed below. If you would prefer that I do not send a letter to any of the physicians you have listed, please indicate so by checking the box at the right side of the chart.

Thank you. *Marie F. Pennanen, M.D.*

Specialty	**Name**	**City/State Street address (if not local)**	**Phone/ Fax (if known)**	**Do NOT send letter to MD**
Primary care physician/internist/ family practitioner			**P:** _____ **F:** _____	
Gynecologist			**P:** _____ **F:** _____	
Medical Oncologist			**P:** _____ **F:** _____	
Radiation Oncologist			**P:** _____ **F:** _____	
Cardiologist			**P:** _____ **F:** _____	
Other (please specify): _____			**P:** _____ **F:** _____	
Other (please specify): _____			**P:** _____ **F:** _____	
Other (please specify): _____			**P:** _____ **F:** _____	

Marie F. Pennanen, M.D., F.A.C.S.
Chevy Chase Surgical Associates, P.C.
Private Surgical Suite, L.L.C.

Patient Registration Form

PATIENT NAME: _____ **DATE**: _____
Last First MI

_____
Home Address: Street Apt. # City State Zip

_____
Home Phone # Work phone # Cell phone and/or Pager # Social Security #

_____
Birth date Sex Age Marital Status Driver's License # and State

_____
Email Address: (For clarity, please print in CAPITAL letters)

EMPLOYED BY:

_____
Name Occupation

_____
Work Address: Street Suite # City State Zip

IN CASE OF EMERGENCY, NOTIFY:

_____
Full Name Cell Phone # Relationship

_____
Home Address: Street City State Zip

REFERRING PHYSICIAN or PERSON: _____

Please complete the insurance information below. We will also make a copy of your insurance card(s) and driver's license for our records.

PRIMARY INSURANCE:_____
Name Address

_____
Subscriber Name **Relationship to Patient** **Subscriber ID #** **Group #**

SECONDARY INSURANCE: _____
Name Address

_____
Subscriber Name **Relationship to Patient** **Subscriber ID #** **Group #**

*****IF YOU ARE NOT THE "SUBSCRIBER," please provide the following information:***

_____
Subscriber Name Date of Birth Cell Phone #

_____
Home Address: Street City State Zip

_____
Name of Subscriber's Employer Occupation Work Phone #

_____
Work Address: Street City State Zip

PATIENT AGREEMENT REGARDING FINANCIAL TERMS AND CONDITIONS

We are committed to providing you with the best possible care and services. If you have medical insurance, we are happy to assist you in filing your claims so that you may receive the maximum allowable benefits from the insurer. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

In the event that Marie F. Pennanen, M.D., Chevy Chase Surgical Associates, P.C., and/or Private Surgical Suite, L.L.C., their physicians, and/or assistants file claims with my insurance for services and supplies provided, I hereby authorize that the payments from my insurance company be made directly to the provider(s) of service(s) for all covered expenses. If a procedure or ultrasound examination is performed, a separate facility fee charge from Private Surgical Suite, L.L.C may apply. I have been informed that Drs. Zorc, Pennanen and Winkler have ownership interests in Private Surgical Suite, L.L.C. and I understand that I have an option to be treated at facilities other than Private Surgical Suite, L.L.C. if desired. If one of our advanced practice providers provides care, there may be a charge for their services. A charge of $60.00 may be assessed for missed appointments without 24 hours advance notice. A charge of $400.00 may be assessed for surgical procedures canceled without 48 hours advance notice.

I understand that whether or not the provider is a participating provider with my insurance plan, it is ultimately my responsibility to ensure the provider is paid for the services rendered. I understand that the filing of insurance claims is a courtesy that is extended to me and the courtesy does not relieve me of my primary responsibility to pay for services rendered to me (or my minor child). It is my responsibility to make sure that my insurance company processes the claims properly and payment is issued promptly to the provider. It is my responsibility to fully understand the terms and conditions of my insurance policy regarding the procedures for the filing of claims, what medical procedures and treatments the insurance policy does and does not cover, what amount, if any, the insurance company will pay for medical services, and what the co-payment and deductible amounts may be. It is my responsibility to make sure the insurance company is notified of any proposed treatments and surgery and that any applicable pre-authorization requirements are fulfilled.

Unless otherwise agreed upon in writing by the provider, payment for services is due at the time of service. Payments can be made with cash, check, and or credit card. Returned checks will be subject to a $35.00. I agree to pay interest of 1.5% per month on any balance past due. If my account is turned over to a collection agency or an attorney for collection, I also agree to pay 100% of collection fees, court costs and other expenses incurred as a result of said collection.

I understand that I can discuss my proposed treatments and charges in advance with the providers of the service.

I understand that unless my provider (Marie F. Pennanen, M.D., Chevy Chase Surgical Associates, P.C., and/or Private Surgical Suite, L.L.C.), is a participating provider with my insurance:

1. I understand that the insurance policy is a contract between the insured and the insurance company and that a non-participating provider is not a party to that contract and therefore not bound by its terms and conditions.

2. I understand that the provider is not bound by the fee payment structure of the insurance plan and I am responsible for whatever portion of any charges the insurance carrier does not pay.

3. I understand that not all services are a covered benefit in all insurance contracts or policies and some insurance companies select certain services they will not cover and that these charges are my responsibility.

4. I understand and agree that if my insurance company sends any payment to me for services provided, I will endorse and forward the payment and send copies of the explanation of benefits to the provider.

We must emphasize that as medical providers, unless we are a participating provider, our relationship is with you, not your health care plan. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I hereby authorize and give consent to any and all of my providers to inquire of my insurance company or companies on behalf of my account, to request information regarding claims paid, denied, or under consideration and to initiate requests for review of claims, appeals and/or complaints on my behalf. I certify that the above information is correct and complete, and further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company in order to determine benefits to which I may be entitled. I agree to provide notification of any address, telephone number and insurance company changes within 30 days if I have outstanding medical bills or unresolved medical issues so that I can be contacted by my provider(s). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

If you have any questions about the above information, or any uncertainty regarding your health care insurance coverage, PLEASE do not hesitate to ask us. We are happy to help you.

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.

Signature (by patient or guardian):_____ Date: _____

PATIENT NAME: _____ Acct #_____

Chevy Chase Surgical Associates, P.C.
Chevy Chase Breast Center

5530 Wisconsin Avenue #1455, Chevy Chase, MD 20815

Contact Information Sheet

Phone Calls Regarding Medical Care

- ☐ Please contact me on my home telephone: _____ - _____ - _____
  - ☐ Leave a name and callback number only.
  - ☐ Leave a detailed message.
- ☐ Please contact me on my cell phone: _____ - _____ - _____
  - ☐ Leave a name and callback number only.
  - ☐ Leave a detailed message.
- ☐ Please contact me on my work phone: _____ - _____ - _____
  - ☐ Leave a name and callback number only.
  - ☐ Leave a detailed message.

Sending You Documents

We may need to send documents to you including imaging requisitions (which will include your medical information), referrals, instructions, etc. Please indicate how you would like to receive these:

- ☐ Mail information to my home address on file.
- ☐ Email information to: _____
  - ☐ I understand that this office does not have a method for encrypting outgoing emails; I acknowledge that I am the only person who has access to this email.

Appointment Reminders

Please indicate the method or methods through which you would like to receive appointment reminders:

- ☐ Email reminders
- ☐ Text message reminders to my cell phone
- ☐ Voice message to my (pick one):

  ☐ home phone ☐ cell phone ☐ work phone

Emergency Contact Information

In case of an emergency, I authorize contacting _____

at _____ - _____ - _____. My relationship to this person is _____.

Medical Information Release

I hereby give permission to release medical information pertinent only to my current medical

condition to (name/relationship) _____.

_____ _____ _____

Patient's Name (Print) Signature of Patient or Legal Guardian Date

Marie F. Pennanen, M.D.
Chevy Chase Surgical Associates, P.C.
Private Surgical Suite, L.L.C.

Privacy Notice Statement ▪ Our Privacy Notice informs you of our use and disclosure of your ***Protected Health Information (PHI)***, defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual". ▪ Our office will use or disclose your PHI for purposes of treatment, payment and other health care purposes (TPO) as required to provide you the healthcare services that we offer. It is our policy to control access to your PHI and, even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access. We define *minimum necessary information* as the minimum necessary to accomplish the intent of the request. ▪ An Authorization differs from this Privacy Notice in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from a Privacy Notice, and usually used only for one specific request for information. In the event of a non-health care related request for personal health information; this office will request you to sign an Authorization Form. Inquiries of a non-medical or non-routine nature will be recorded and maintained for a period of six years from the date of the last request and can be viewed by you, the patient, at your written request. Inquiries resulting from your Authorization may not be tracked under the assumption that you are already aware of them. ▪ You, as our patient, may revoke your Authorization or restrict the disclosure of your healthcare information in writing at any time and our use and disclosure will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent or the Authorization, you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization. Any revocation will not apply to information previously used or disclosed. ▪ If you had a "personal representative" initiate your Authorization, you may revoke the authorization at any time. ▪ You, the patient, have access to your health care information and may request to see your information, may request copies of your information, and under the law, you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, the covered entity is bound by law to abide by the changes. ▪ In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that require the disclosure of health care information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail. ▪ In some occasions, this office may furnish your PHI to a third party, such as an insurance company for the purpose of payment, or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not re-disclose your PHI. § Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign the agreement as a condition of receiving care. It is the law that your rights are communicated in this manner. We seek only to obtain your signature and date to affirm that you have received the Privacy Notice, not that you have read it or agree with it. It is an expression of our practices and your rights. ▪ In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in HIPAA Privacy Standard requirements, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your PHI. This office is taking steps and continues to monitor and improve processes for the protection of your information and to remain in compliance with the law. §

Please sign below and date the form indicating only that you have received this Privacy Notice.

Signature of Patient or Personal Representative _____

Date_____