hsmf women's care

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PLEASE FILL OUT ALL INFORMATION COMPLETELY AND ACCURATELY
Failure to do so may give you a larger out of pocket expense

Last Name _____ First Name _____ MI _____

Address _____ Apt # _____

City _____ State _____ Zip _____ Date of Birth _____/_____/_____

Home Phone _____ Cell Phone _____ Work Phone _____ Preferred #: □ H □ C □ W

Email Address _____ Marital Status: S M W D

Leave detailed messages including results on: □ Cell Phone □ Home Phone □ Work Phone □ None

Leave message with callback number Only: □ Cell Phone □ Home Phone □ Work Phone

In case we cannot reach you please provide us with someone we can contact in an Emergency:

Name: _____ Phone #: _____ Relationship to you: _____

Do you have any person that you authorize to receive and discuss information regarding your personal health information (medical results, surgical, financial, etc.)? □ No □ Yes (List Below)

Name: _____ Phone #: _____ Relationship to you: _____

Pharmacy Name, Phone # & Address _____

Name & Phone # of Referring Physician or PCP _____

Primary Language: □ English □ Spanish □ Greek □ Italian □ Other _____

Race: □ American Indian or Native Alaskan □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Island □ Other Race □ White

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Student Status: □ Not a Student □ Part-time □ Full-time Mother's Maiden Name _____

PLEASE COMPLETE YOUR INSURANCE INFORMATION AND

PROVIDE A COPY OF CURRENT INSURANCE CARD

Primary Insurance _____

Insurance mailing address_____

_____

Insurance ID or Policy #_____

Policy Holder's Full Name _____ □ Male □ Female

Policy Holder's Date of Birth _____/_____/_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance_____

Insurance mailing address_____

_____

Insurance ID or Policy # _____

Policy Holder's Full Name _____ □ Male □ Female

Policy Holder's Date of Birth _____/_____/_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other: _____

FAILURE TO PROVIDE YOUR CORRECT INSURANCE COVERAGE WILL RESULT IN YOU BEING RESPONSIBLE FOR THE ENTIRE BALANCE

The Insurance information I have provided above is correct and complete

Signature _____ Date _____/_____/_____

AUTHORIZATION INFORMATION

PLEASE READ AND SIGN BELOW

We are now required by Federal Law to:

Maintain the privacy of Protected Health Information and give you notice of our legal duties and privacy practices regarding health information about you. We are also required to protect your identity. As a result you will be required to provide proof of identity at all encounters with the office. In addition, we will ask you to fill out a new demographics sheet every year and confirm your information every 6 months.

Please be assured that this office has always considered the privacy and confidentiality of your medical records. We must have your written authorization to have your records sent to you or another physician. If you wish to read the full text, please ask our Office Manager.

Please be advised that as per contractual agreement with your insurance carrier as in-network providers, it is mandatory that we collect **ALL** co-pays, deductibles, and coinsurance as determined by your plan. In addition, you must provide us with up-to-date insurance information and elected the proper physician as your GYN, if required. Regrettably, we may not be able to determine the extent of your payment responsibility at the time of your visit. In addition you must present your current insurance card at every visit.

I, _____, understand that I am responsible for payment of any applicable deductibles, co-payments and co-insurance for services rendered by *hsmf women's care*. I also understand that I will receive a separate bill from a lab for any lab testing performed. I understand that I am responsible for providing *hsmf women's care* with up to date insurance information and to bring my insurance card to every visit. If I fail to provide this information, I understand that I may be responsible for the entire bill or portion thereof that my insurance has not covered.

I understand and agree to all of the above

Signature _____ Date _____/_____/_____

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I, _____, hereby authorize HSMF Women's Care to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, labs, radiology facilities, or other institutions.

This authorization remains in effect until revoked.

DOB: _____/_____/_____

Signature _____ Date ____/____/_____

Personal and Family History Questionnaire for Hereditary Cancer Risk Assessment

TODAY'S DATE:	PATIENT NAME:	DATE OF BIRTH:	AGE:

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces and nephews

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU Age	SIBLINGS / CHILDREN Family Member and Age	MOTHER'S SIDE Family Member and Age	FATHER'S SIDE Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 relatives with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger	○ Y ○ N				
3 or more of these cancers on same side of the family at any age: **pancreatic, breast**, or **aggressive prostate**	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Jewish ancestry with **breast cancer** at any age	○ Y ○ N				
Jewish ancestry with **pancreatic cancer** and one relative with **breast, ovarian, pancreatic** OR **aggressive prostate cancer**	○ Y ○ N				
10 or more **pre-cancerous colon polyps** found in 1 person throughout their lifetime. Total number_____	○ Y ○ N				
Colorectal or **Uterine (endometrial) cancer** before age 50	○ Y ○ N				
TWO individuals in my family (myself included): at least 1 with **colorectal *or* uterine (endometrial) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○ Y ○ N				
THREE OR MORE individuals in my family (myself included) with a **Lynch-associated* cancer** at any age, with at least 1 being a colorectal or uterine (endometrial) cancer	○ Y ○ N				

* **Lynch-associated cancers include: colon, uterine (endometrial), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).**

Have you or a family member had genetic testing for a **BRCA, Lynch or polyposis mutation**?	○ Y ○ N	If yes, who in your family had testing, when, and if known, where?:

OFFICE USE ONLY

- Does patient meet: 1. NCCN guidelines for HBOC? ○ Y ○ N 2. NCCN guidelines for (A)FAP? ○ Y ○ N
  3. SGO guidelines for Lynch syndrome? ○ Y ○ N
- Genetic testing recommended? ○ Y ○ N
- If YES, which test? ○ BRAC*Analysis*® with Myriad myRisk™ ○ COLARIS® with Myriad myRisk™
  ○ COLARIS*AP*® with Myriad myRisk™ ○ Multi-Site with Reflex Myriad myRisk™ ○ Single Site _____
- Provide rationale for recommendation: ○ Guidelines met ○ Other (please specify): _____
- Patient accepts same day genetic testing: ○ Y ○ N
- Patient advised to schedule follow-up appointment: ○ Y ○ N

PROVIDER'S SIGNATURE:	TODAY'S DATE:

Patient Signature: _____