



hera sambaziotis, md, mph, facog & martina frandina, md, facog

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: \_\_\_\_\_

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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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1991 Marcus Avenue, Suite M101, Lake Success, New York 11042  
516.437.2020 516.437.2019 (fax)

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:
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## 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	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
	Age	Family Member and Age	Family Member and Age	Family Member and Age
<b>EXAMPLE:</b> Breast cancer	<input checked="" type="radio"/> Y <input type="radio"/> N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45 Grandma 84
Breast cancer at or before age 45	<input type="radio"/> Y <input type="radio"/> N			
2 or more separate <b>breast cancers</b> in one person, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N			
2 relatives with <b>breast cancer</b> , one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N			
<b>Ovarian cancer</b> at any age	<input type="radio"/> Y <input type="radio"/> N			
<b>Triple Negative Breast cancer</b> at age 60 or younger	<input type="radio"/> Y <input type="radio"/> N			
3 or more of these cancers on same side of the family at any age: <b>pancreatic, breast, or aggressive prostate</b>	<input type="radio"/> Y <input type="radio"/> N			
Male <b>breast cancer</b> at any age	<input type="radio"/> Y <input type="radio"/> N			
Jewish ancestry with <b>breast cancer</b> at any age	<input type="radio"/> Y <input type="radio"/> N			
Jewish ancestry with <b>pancreatic cancer</b> and one relative with <b>breast, ovarian, pancreatic OR aggressive prostate cancer</b>	<input type="radio"/> Y <input type="radio"/> N			
10 or more <b>pre-cancerous colon polyps</b> found in 1 person throughout their lifetime. Total number _____	<input type="radio"/> Y <input type="radio"/> N			
<b>Colorectal or Uterine (endometrial) cancer</b> before age 50	<input type="radio"/> Y <input type="radio"/> N			
TWO individuals in my family (myself included): at least 1 with <b>colorectal or uterine (endometrial) cancer</b> at any age <b>AND ALSO</b> 1 diagnosed before age 50 with a Lynch-associated* cancer	<input type="radio"/> Y <input type="radio"/> N			
THREE OR MORE individuals in my family (myself included) with a <b>Lynch-associated* cancer</b> at any age, with at least 1 being a colorectal or uterine (endometrial) cancer	<input type="radio"/> Y <input type="radio"/> 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 <b>BRCA, Lynch or polyposis mutation</b> ?	<input type="radio"/> Y <input type="radio"/> N	If yes, who in your family had testing, when, and if known, where?:
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OFFICE USE ONLY	<ul style="list-style-type: none"> <li>Does patient meet: 1. NCCN guidelines for HBOC? <input type="radio"/> Y <input type="radio"/> N 2. NCCN guidelines for (A)FAP? <input type="radio"/> Y <input type="radio"/> N 3. SGO guidelines for Lynch syndrome? <input type="radio"/> Y <input type="radio"/> N</li> <li>Genetic testing recommended? <input type="radio"/> Y <input type="radio"/> N</li> <li>If YES, which test? <input type="radio"/> BRCA<sup>Analysis</sup>® with Myriad myRisk™ <input type="radio"/> COLARIS® with Myriad myRisk™ <input type="radio"/> COLARISAP® with Myriad myRisk™ <input type="radio"/> Multi-Site with Reflex Myriad myRisk™ <input type="radio"/> Single Site _____</li> <li>Provide rationale for recommendation: <input type="radio"/> Guidelines met <input type="radio"/> Other (please specify): _____</li> <li>Patient accepts same day genetic testing: <input type="radio"/> Y <input type="radio"/> N</li> <li>Patient advised to schedule follow-up appointment: <input type="radio"/> Y <input type="radio"/> N</li> </ul>
	PROVIDER'S SIGNATURE: _____

TODAY'S DATE: