PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST

PATIENT NAME_______________________________________ DATE OF BIRTH__________

MAILING ADDRESS____

CITY_________________________STATE______ZIP______ HOME PHONE_____________

SOCIAL SECURITY #_______________________ MARITAL STATUS ___________________

PATIENT'S EMPLOYER______________________________ WORK PHONE______________

OCCUPATION_________________________ CELL PHONE___________________________

I GIVE MY CONSENT TO LEAVE DETAILED MEDICAL INFORMATION ON MY CELL PHONE ___YES ___ NO

PHARMACY OF CHOICE____

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME______________________________ RELATIONSHIP TO PATIENT_______________

PHONE NUMBER_______________________ WORK PHONE__________________________

*****IF MARRIED, PLEASE INDICATE SPOUSE'S NAME AND DAYTIME PHONE*****

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

NAME______________________________ RELATIONSHIP TO PATIENT_______________

ADDRESS____________________________ CITY________________ STATE_____ ZIP_______

PHONE NUMBER_____________________ WORK PHONE____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE CO____

POLICY NUMBER____GROUP NUMBER__________

POLICY HOLDER_____________________________ POLICY HOLDER DOB______________

RELATIONSHIP TO PATIENT______________________________

SECONDARY INSURNCE CO____

POLICY NUMBER____ GROUP NUMBER__________

POLICY HOLDER_____________________________ POLICY HOLDER DOB______________

_______________ ____

DATE SIGNATURE

RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND DIRECT BROOME OBSTETRICS AND GYNECOLOGY, P.C., HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, HOSPITALS, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH MEDICAL CARE AND TO PERMIT REPRESENTATIVE THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT.

____ _______________

SIGNATURE OF PATIENT OR AUTH. REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO BROOME OBSTETRICS AND GYNECOLOGY, P.C. SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID MEDICAL GROUP. I AM AWARE THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY MONIES NOT CONTRACTUALLY COVERED BY MY INSURANCE PLAN. I AM ALSO AWARE OF TIMELY FILING LIMITS FOR MY INSURANCE AND REALIZE IF I DO NOT MEET THAT EXPECTATION I COULD ALSO BE FINANCIALLY RESPONSIBLE FOR ANY REMAINING BALANCE.

____ _______________

SIGNATURE OF PATIENT OR AUTH. REPRESENTATIVE DATE

PRIVAY RELEASE

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF BROOME OBSTETRICS AND GYNECOLOGY, P.C.

____ _______________

SIGNATURE OF PATIENT OR AUTH. REPRESENTATIVE DATE

********* PAYMENT IS DUE AT THE TIME OF SERVICE**********

MEDICARE PATIENTS ONLY

I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS CARRIERS, ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE TO ME OR TO BROOME OBSTETRICS AND GYNECOLOGY, P.C.

____ _______________

SIGNATURE OF PATIENT OR AUTH. REPRESENTATIVE DATE

Patient Name ______________________________ DOB ____________________

FAMILY HISTORY

Illness	Relative	Age onset
Y N Breast Cancer		
Y N Colon Cancer		
Y N Heart Disease		
Y N Depression/Anxiety		
Y N Thyroid Disease		
Y N Bleeding Disorders		
Y N Birth Defects		
Y N Diabetes		
Y N Ovarian Cancer		
Y N Other Cancer		
Y N Hypertension		
Y N Stroke		
Y N Osteoporosis		
Y N Mental Retardation		
Y N Genetic Disease		
Y N Other		

SOCIAL HISTORY

Tobacco Use **Y N** How Much____________ Number of Years________________

Alcohol Use **Y N** How Much____________

Recreational Drug Use **Y N** How Much____________ Number of Years________

Calcium Intake **Y N** Calcium Supplement **Y N** ____________________________

Caffeine Intake **Y N** How Much____________________

Exercise **Y N** How often__________ Type______________________

MEDICATIONS (INCLUDING OVER THE COUNTER)

Medication	Medication	Medication

See Attached List _____________

MENSTRUAL HISTORY

Age at first menstrual period ______________________

Cycle length________________ Flow length____________________

Menstrual flow – Light_____ Moderate______ Heavy ______

If you have stopped having menstrual periods, at what age did you have your last one ______________

Date Updated and Reviewed

________ ________ ________ ________ ________ ________ ________

Patient Name ___________________________ Date ___________________________

Date of Birth ___________________________ Primary Care Physician _______________

Referred By ___________________________ Physician Address _______________

Specialists ___________________________

ALLERGIES (REACTIONS) _____________ (__________) _____________ (__________)

_____________ (__________) _____________ (__________) _____________ (__________)

PERSONAL MEDICAL HISTORY:

Y N	Heart Disease	Y N	Hypertension	Y N	High Cholesterol
Y N	Stroke	Y N	Bleeding Disorders	Y N	Mitral Valve Prolapse
Y N	Asthma	Y N	Thyroid Disease	Y N	HIV
Y N	Osteopenia	Y N	Osteoporosis	Y N	Joint Replacement
Y N	Diabetes	Y N	Anxiety	Y N	Depression
Y N	GERD	Y N	Peptic Ulcer Disease	Y N	Migraines
Y N	Cancer	Y N	Seizures	Y N	STD Exposure

Other ____

GENETIC TESTING:

Y N BRCA Who was tested __________________ Discussed _______________

Results ____

Y N Multi-Gene Who was tested __________________ Discussed _______________

Results ____

FAMILY PLANNING: ____

OPERATIONS/HOSPITALIZATIONS:

Date	Procedure	Physician

OBSTETRICAL HISTORY:

Date	Type of Delivery (Complications)	Physician

DEXA scan Y N Date/Where ________________ ________________ ________________

Colonoscopy Y N Date/Where ________________ ________________ ________________

Gardasil Vaccine Y N Date/Where ________________ ________________ ________________

Date Updated and Reviewed

________ ________ ________ ________ ________ ________ ________

Name:________________________ Date:______ Primary Care Provider:____________________________

Last menstrual period: _____ Current Medications:____

Please check any of the following symptoms that apply to you. Thank You.

CONSTITUTIONAL	YES	NO
Weight loss	__	__
Weight gain	__	__
Change in height	__	__
Fever	__	__
EYES/EARS/NOSE/THROAT		
Vision changes	__	__
Earaches	__	__
Hearing problems	__	__
Sore throat	__	__
Mouth sores	__	__
CARDIOVASCULAR		
Chest pain	__	__
Swelling of legs	__	__
Rapid/irregular heartbeat	__	__
RESPIRATORY		
Coughing up blood	__	__
Shortness of breath	__	__
Chronic cough	__	__
Wheezing	__	__
GASTROINTESTINAL		
Frequent diarrhea	__	__
Bloody stool	__	__
Nausea/vomiting	__	__
Constipation	__	__
Change in bowel habits	__	__
Abdominal bloating	__	__
Frequent indigestion	__	__
Hemorrhoidal pain	__	__
URINARY		
Blood in urine	__	__
Pain with urination	__	__
Strong urgency to urinate	__	__
Frequent urination	__	__
Incomplete emptying	__	__
Involuntary urine loss	__	__
Urine loss w/cough/lift	__	__
GYNECOLOGICAL		
Abnormal bleeding	__	__
Painful periods	__	__
Painful intercourse	__	__
Abnormal vaginal discharge	__	__
Itching	__	__
Possible contact with sexually transmitted disease	__	__
Bleeding with intercourse	__	__
INFECTIONS		
MRSA (Staph)	__	__
Drug resistant infection	__	__

MUSCULOSKELETAL	YES	NO
Muscle weakness	__	__
Muscle/joint pain	__	__
SKIN		
Bruises	__	__
Rash	__	__
Changes in moles	__	__
BREASTS		
Pain in breasts	__	__
Nipple discharge	__	__
Lumps	__	__
NEUROLOGIC		
Seizures	__	__
Dizziness	__	__
Numbness	__	__
Frequent/severe headaches	__	__
PSYCHIATRIC		
Feeling down/sad	__	__
Feeling anxious	__	__
ENDOCRINE		
Heat/cold intolerance	__	__
Abnormal thirst	__	__
Hot flashes	__	__
Chronic fatigue	__	__
HEMATOLOGIC/LYMPHATIC		
Cuts that do not stop bleeding	__	__
Enlarged lymph nodes/glands	__	__

ALLERGIES:

____

Other allergies:

List:____________________________________

Do you drink alcohol? __ __

How much?________________________________

Do you smoke? __ __

How much?________________________________

Do you exercise? __ __

Would you like information on domestic violence? __ __

Hereditary Cancer Syndrome Risk Assessment

Patient Name: ______________________ Provider: ______________________

Date of Birth: __________ Date Completed: __________ Insurance: ______________________

This is a screening tool for the common features of inherited cancer syndromes. Your health care provider requests this information in order to provide you with the best care possible. Please complete as best you can, thank you!

- Please Circle (Y) for those that apply to **YOU** and/or **YOUR FAMILY** (on both your mother's and father's side).
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family members should be considered:

Mother, Father, Brother, Sister, Children, Nieces/Nephews
Paternal and Maternal Grandmothers, Grandfathers, Great Grandparents, Aunts, Uncles, Cousins

Y	N	Have you or a family member ever been tested for hereditary risk of cancer (genetic testing for BRCA, Lynch Syndrome or any other syndromes)? If yes, please describe:					
		BREAST AND OVARIAN CANCER	SELF SIBLING CHILD	Relative Maternal	Relative Paternal	AGE @ DIAGNOSIS	Deceased? Y or N
Y	N	Breast cancer diagnosed at **50 years of age or younger** in you or any family members?					
Y	N	**Ovarian cancer** diagnosed in you or ANY other family members at **ANY** age?					
Y	N	**Male breast cancer** diagnosed in any family members at **ANY** age?					
Y	N	**Pancreatic cancer** diagnosed in any family members at **ANY** age?					
Y	N	**Three or more** cancers diagnosed on the **same side** of your family: **breast**, **prostate**, melanoma, ovarian/fallopian tube/peritoneal?					
Y	N	**Jewish** Ancestry with breast, pancreatic or ovarian cancer diagnosed in you or any family members?					
		COLON AND UTERINE CANCER	SELF SIBLING CHILD	Relative Maternal	Relative Paternal	AGE @ DIAGNOSIS	Deceased? Y or N
Y	N	Endometrial (Uterine) cancer **before age 50** diagnosed in any family members? **(if Self <64)**					
Y	N	Colon/Rectal cancer **before age 50** diagnosed in any family members? **(if Self <64)**					
Y	N	**Three or more** cancers diagnosed on the **same side** of your family: **colon**, **uterine**, ovarian, stomach, small bowel, kidney/urinary tract, pancreatic, or brain?					
Y	N	10 or more **cumulative colon polyps** (**precancerous adenomas**) in you or a family member?					

X- Patient's Signature: ______________________ **Date:** __________

***** FOR OFFICE USE ONLY *****

Patient indicated for hereditary cancer genetic testing? ☐ **YES** ☐**NO** ☐ **ACCEPTED** ☐**DECLINED**

Reason______________________

☐Integrated BRAC*Analysis*® with Myriad myRisk™
☐COLARIS®PLUS with Myriad myRisk™
☐COLARIS AP®PLUS with Myriad myRisk™

Healthcare Provider's Signature: ______________________ **Date:** __________