Seasons Women's Care – Patient Registration Form

Name: ______________________________ Date of Birth: ____________

Address: ______________________________ City: __________ St: ______ Zip ________

Home Phone: ______________ Cell: ______________ Best Number: ______________

Email: ______________________________ Race or Ethnicity: ________

Marital Status: ______________ SS# ______________ Drivers Lic#: ______________

Employer: ______________ Work# ______________ Occupation: ______________

Spouse Name: ______________ Phone# ______________ Employer: ______________

Emergency Contact: ______________ Phone# ______________ Relationship: ________

Primary Insurance Company Name: ______________________________

Subscriber's Name & date of birth, if not patient: ______________ DOB: ________

Primary Care Doctor's Name: ______________________ Phone # ______________

Pharmacy Name: ______________________ Phone# ______________

How did you hear about our practice? ______________________________

I certify that the above information is correct, and further authorize the release of any medical information to any insurance carrier for any claim. I request payment of authorized benefits for physician services to the physicians or providers at Seasons Women's Care. I understand that I am responsible for any charges not paid by my insurance company. I also agree that should this account be referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. I am aware that payment is expected when services are rendered. I am aware that there is a $35 no show fee for appointments. If I need surgery, and the OR is booked, there is a $200 surgery cancellation fee if I cancel. I am also aware that should I need any disability paperwork filled out by my doctor that there is a $35 cash fee charge for this.

Signature of responsible party: ______________________ Date: ______________

Today's Date: ________

Clinical Update Form

Name: ______________________ Change in marital status: ________

Reason for today's visit: ______________________

Date of last pap smear: ____________ Date of last bone density scan: ________

Date of last mammogram: ____________ Location of mammogram: ________

Are there any new medical problems that you have been diagnosed with since your last visit?

☐ No ☐ Yes, specify: ______________________

____

Have you had any surgeries since your last visit?

☐ No ☐ Yes, specify: ______________________

____

Please list all medication that you currently take: ______________________

____

Do you have any new allergies? ☐ No ☐ Yes, specify: ______________________

Have you had any changes in your menstrual cycle? Date of Last Menstrual Cycle: ________

☐ No ☐ Yes, specify: ______________________

Are there any medications that you need a prescription for today?

☐ No ☐ Yes, specify: ______________________

Are there any new concerns that you have and would like to discuss with your Doctor?

☐ No ☐ Yes, specify: ______________________

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Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

Y N Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain: ______________________

____
Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC
☐ Information given to patient to review
☐ Follow-up appointment scheduled Date: __________

☐ Patient offered genetic testing:
☐ Accepted
☐ Declined

____
Healthcare Professional's Signature Date

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

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