



**PATIENT INTAKE**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
LAST FIRST

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED OCCUPATION: \_\_\_\_\_

PAST MEDICAL & FAMILY HISTORY	PLEASE MARK (X) IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS					
	SELF	FAM	OTHER/COMMENTS		SELF	FAM
RHEUMATIC HEART				ANEMIA		
HIGH BLOOD PRESSURE				BLOOD CLOTS (DVT)		
HIGH CHOLESTEROL				DIABETES		
CONGESTIVE HEART				THYROID DISEASE		
ASTHMA				EPILEPSY		
COPD				ALZHEIMERS		
HEPATITIS				OSTEOPOROSIS		
GERD				ANXIETY/DEPRESSION		

OBSTETRIC HISTORY	#TOTAL PREGNANY		# TERM DELIVERY		#PRETERM DELIVERY		#ABORTION/ MISCARRIAGE		#LIVING CHILDREN
DATE OF BIRTH	SEX		DELIVERY TYPE			REMARKS			

GYNECOLOGIC HISTORY	AGE AT FIRST PERIOD		AGE AT LAST PERIOD
	PERIOD INTERVAL (1 <sup>ST</sup> DAY TO 1 <sup>ST</sup> DAY)		DURATION OF BLEEDING
PAP TEST	DATE OF LAST TEST <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		MAMMOGRAM DATE OF LAST TEST <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
SEXUALLY TRANSMITTED DISEASES	<input type="checkbox"/> HERPES <input type="checkbox"/> SYPHILIS <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> GONORRHEA <input type="checkbox"/> HIV/AIDS		
CONTRACEPTIVE HISTORY	CURRENT CONTRACEPTIVE		
SOCIAL HISTORY	SMOKING CIG/ DAY	# YEARS	ALCOHOL DRINKS/ WK
	DO YOU FEEL SAFE AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO		HISTORY OF ABUSE <input type="checkbox"/> YES <input type="checkbox"/> NO

MEDICATIONS	DOSE	ALLERGIES TO MEDICATION	REACTION

SURGERY	DATE	SURGERY	DATE

REVIEW OF SYSTEMS	PLEASE MARK (X) ALL THAT APPLY				
	YES	NO		YES	NO
<b>GENERAL</b>			<b>CARDIOVASCULAR</b>		
WEAKNESS			CHEST PAIN DURING EXERTION		
UNEXPLAINED WEIGHT LOSS			DECREASED EXERCISE TOLERANCE		
PERSISTENT FEVER			SWELLING OF HANDS OR LEGS		
<b>SKIN</b>			PALPITATIONS		
JAUNDICE			<b>RESPIRATORY</b>		
HIVES, ECZEMA OR RASH			CHRONIC COUGH		
FREQUENT BOILS OR INFECTION			ASTHMA OR WHEEZING		
ABNORMAL PIGMENTATION			BLOOD IN SPUTUM		
EASY TO BRUISE			<b>GASTROINTESTINAL</b>		
<b>NEUROLOGIC</b>			HEARTBURN OR INDIGESTION		
CONVULSIONS			NAUSEA OR VOMITING		
MEMORY LOSS			DIARRHEA		
HEADACHES			CONSTIPATION		
POOR COORDINATION			BLOOD IN STOOL		
<b>EYES/EARS/NOSE/THROAT</b>			ABDOMINAL PAIN OR CRAMPS		
DOUBLE VISION OR BLURRY VISION			EARLY SATIETY		
FLOATERS			LOSS OF APPETITE		
LOSS OF HEARING			<b>REPRODUCTIVE</b>		
RINGING IN EARS			IRREGULAR MENSTRUATION		
LOSS OF SMELL			LOSS OF MENSTRUATION		
BREAST			HEAVY BLEEDING		
LUMPS			PAIN WITH INTERCOURSE		
DISCHARGE			LOSS OF LIBIDO		
TENDERNESS			SPOTTING		
<b>ENDOCRINE</b>			<b>UROLOGIC</b>		
EXCESS THIRST			FREQUENT OR PAINFUL URINATION		
EXCESS URINATION			BLOOD IN URINE		
HEAT OR COLD INTOLERANCE			LOSS OF URINE CONTROL		
<b>PSYCHOLOGIC</b>			<b>MUSCULOSKELETAL</b>		
FEELINGS OF GUILT			MUSCLE CRAMPS		
THOUGHTS OF HURTING SELF			PAINFUL JOINTS		
THOUGHTS OF HURTING OTHERS			SWOLLEN JOINTS		

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY MD: \_\_\_\_\_ DATE: \_\_\_\_\_

**TRINITY WOMEN'S HEALTH OFFICE POLICIES**

**Your appointment will be rescheduled** if you arrive more than **10** minutes late to your scheduled appointment time for established patients. New patients must be here **30** minutes prior to appointment.

Any voicemails left will be checked throughout the same business day

There is a 72 hour turn around for all **prescription refills**. If you need a prescription refill have your pharmacist fax a refill request to our fax number (951) 677-8080 and we will take care of accordingly.

There will be a \$30.00 **CASH** fee on all personal paperwork completed by our physicians (DMV forms, EDD forms, FMLA forms, etc...)

There is a **\$50.00 fee for any missed appointments not cancelled 24 hours in advance**. Please contact us as soon as possible to cancel your appointment.

**PHARMACY LISTINGS**

To facilitate your prescription orders and refills, we ask that you fill out 2 pharmacy locations that you frequently use so that we may fax prescriptions in and expedited manner. **If there are any changes to your current pharmacy location information, please notify us immediately so that there is no delay in processing your prescription requests.**

**Pharmacy Choice # 1:**

Name of Pharmacy	Address	Phone number
------------------	---------	--------------

**Pharmacy Choice # 2:**

Name of Pharmacy	Address	Phone number
------------------	---------	--------------

**PATIENT CONSENTS**

PLEASE INITIAL SPACES BELOW

- I authorize the release of any Medical Information to process claims. \_\_\_\_\_
- I authorize the release of payment for Medical Benefits to Trinity Women's Health. \_\_\_\_\_
- I consent to and authorize the performance of all treatments, surgery, and medical health services by the staff of Trinity Women's Health which they deem advisable. I certify that to the best of my knowledge, all statements contained hereon are true. I understand I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. \_\_\_\_\_
- I agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount I may owe. I also authorize Trinity Women's Health to release information requested by my insurance company and/or its representatives. \_\_\_\_\_
- I authorize Trinity Women's Health to photograph me and/or my medical condition for medical records. \_\_\_\_\_
- I acknowledge the HIPAA (privacy practices notice) is available to print online or available on request. \_\_\_\_\_
- **I give permission to this office to release medical and billing information on my behalf, to the following person(s).**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PATIENT NAME /GUARDIAN (PLEASE PRINT) \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

## PRIVATE POLICY STATEMENT

**PURPOSE:** The following policy is adopted to ensure that Trinity Women's Health complies fully with all federal and state privacy protection laws including HIPAA and California law. Violations of these policies will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution

**NOTICE OF PRIVACY PRACTICE:** It is the policy of Trinity Women's Health that a notice of privacy practices must be published, that a copy of this notice provided to patients at first encounter, and that all uses and disclosures of health information be done in accord with this policy. It is also the policy of the medical practice to post the most current privacy practices in the waiting room and to have copies available for distribution at our reception area.

**ASSIGNING PRIVACY AND SECURITY RESPONSIBILITIES:** It is the policy of Trinity Women's Health that specific individuals under our employment are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Act's requirements. It is further the policy that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum, it is the policy of the medical practice that there will be one individual designated as the Privacy Official.

**DECEASED INDIVIDUALS:** It is the policy of Trinity Women's Health to extend privacy protections to information regarding deceased individuals

**MINIMUM NECESSARY USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:** It is the policy of Trinity Women's Health that for all routine and recurring uses and disclosures of protected health information except for disclosures made for treatment purposes, or as authorized by patient or as required by law for HIPAA compliance, that such uses and disclosures be limited to the minimum amount of information needed to accomplish the purpose or use of disclosure. It is further policy that non-routine uses and disclosures be handled pursuant to established criteria. All requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

**MATERIAL CHANGE:** It is the policy of Trinity Women's Health that the term "material change" refers to any change in our HIPAA compliance activities

**SANCTIONS:** It is the policy of Trinity Women's Health that sanctions will be in effect for any member of our staff who intentionally or unintentionally violates any of these policies or procedures related to fulfillment of these policies. Such sanctions will be kept as a permanent record on the individual's personnel file.

**RETENTION OF RECORDS:** It is the policy of Trinity Women's Health that the HIPAA Privacy Act records retention requirement of six years will be adhered to. All records designated by HIPAA will be maintained in a manner that allows for access within a reasonable amount of time. This records retention time may be extended at this medical practice's discretion to meet with other governmental regulations or requirements imposed by professional liability carriers.

**COOPERATION WITH PRIVACY OVERSIGHT AUTHORITIES:** It is the policy of Trinity Women's Health that oversight agencies such as the Office of Civil Rights of the Department of Health and Human Services be given full cooperation in their efforts to ensure protection of health information within the organization. All personnel must fully cooperate with privacy compliance reviews and investigations.



Please read the following financial policies of this office:

**NOTE: YOU WILL RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR ANY LABORATORY SERVICES ORDERED (I.E., PAP SMEAR, URINALYSIS, BIOPSIES, CULTURES, BLOOD WORK, ETC.). THESE CHARGES ARE NOT INCLUDED IN OUR BILL. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY FOR PAP SMEARS, BLOOD WORK, ETC., YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE BEFORE THE END OF YOUR APPOINTMENT.**

**PRIVATE INSURANCE:** As a courtesy, we will bill your insurance company. We will, however, collect all percentages and/or deductibles at the time of your visit. If your insurance company requires their insurance claim form be utilized, rather than the universal HCFA 1500, it will be the patient's responsibility for providing the form prior to their office visit. If such a form is unavailable, then we will collect all charges and then you will be responsible for billing your insurance company.

**SURGERY:** The office will bill for all surgery charges. Please assign authorization of payment directly to the physician. Prior to your surgery, please make arrangements for payment of any deductibles and/or co-payments. If you are not covered by insurance, payment in full will be expected on the day of your pre-operative appointment. Please be aware that there may be an assistant fee, anesthesiologist fee, laboratory fee, and radiologist fee, etc.

**PREFERRED PROVIDER ORGANIZATIONS (PPO or HMO):** If you are covered by an insurance company that we are contracted with, please present your membership card at the front desk. We will bill your insurance company. Any co-payment will be expected at the time of your visit. Please be aware that a prior authorization may be necessary for your visit and must be obtained prior to your visit. Prior authorization is a requirement of many HMO's and their procedures and policies MUST be followed.

**SECONDARY INSURANCE:** Our office will bill your secondary insurance as long as the secondary allowable is greater than the primary allowable. Our office will bill your secondary insurance as a courtesy to you one time. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. At your request, we will assist you with any information you may need to bill your secondary again.

**CASH:** If you do not have insurance, you will be expected to make payment at the time of service. Please stop at the front desk after each Gynecological or Obstetrical visit.

**ALL OBSTETRICAL PATIENTS:** An account will be established on your first visit. If you have pregnancy health insurance coverage it will not be billed until you have delivered. However, any additional fees not included in your obstetrical care, such as ultrasounds, are due and payable at the time of service. You will also be responsible for all co-payments and deductibles to be paid in full by your 24th week of pregnancy. Payment arrangements should be arranged on your first visit. If you are a member of a PPO or HMO, your co-payments will be expected at each visit, if applicable. An obstetrical contract will be generated and mailed to you by our biller Susan Ford (951) 694-6102. If you have any questions, please feel free to stop at the front desk. We are here to help you in any way possible.

I have read the above information and understand my financial obligation to Trinity Women's Health

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# CANCER FAMILY HISTORY QUESTIONNAIRE

## Personal Information

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Gender (M/F):** \_\_\_\_\_ **Today's Date(MM/DD/YY):** \_\_\_\_\_ **Healthcare Provider:** \_\_\_\_\_

**Instructions:** This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

**You and the following close blood relatives should be considered:** You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren

## YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<b>EXAMPLE:</b> BREAST CANCER	45	-----	---	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER (Female or Male)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	ENDOMETRIAL (Uterine) CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME COLON/RECTAL POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

Y  N Are you of Ashkenazi Jewish descent?

Y  N Are you concerned about your personal and/or family history of cancer?

Y  N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

If Yes, Who? \_\_\_\_\_ What gene(s)? \_\_\_\_\_ What was the result? \_\_\_\_\_

## Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

<input type="checkbox"/>	<b>Multiple</b> A combination of cancers on the same side of the family:	<input type="checkbox"/> <b>2 or more:</b> breast / ovarian / prostate / pancreatic cancer <input type="checkbox"/> <b>2 or more:</b> colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) <input type="checkbox"/> <b>2 or more:</b> melanoma / pancreatic
<input type="checkbox"/>	<b>Young</b> Any 1 of the following at age <b>50 or younger</b> :	<input type="checkbox"/> Breast cancer <input type="checkbox"/> Colon/rectal cancer <input type="checkbox"/> Endometrial cancer
<input type="checkbox"/>	<b>Rare</b> Any 1 of these rare presentations at <b>any age</b> :	<input type="checkbox"/> Ovarian cancer (Peritoneal/Fallopian tube) <input type="checkbox"/> Breast: Male breast cancer or Triple negative breast cancer <sup>¶</sup> (ER-, PR-, HER2- Pathology) <input type="checkbox"/> Ashkenazi Jewish ancestry with an HBOC-associated cancer <sup>¶</sup> <input type="checkbox"/> Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology <sup>††</sup> <input type="checkbox"/> Endometrial cancer with abnormal MSI/IHC <input type="checkbox"/> 10 or more colon/rectal polyps*

<sup>¶</sup> HBOC-Associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score ≥ 7)

<sup>††</sup> Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern \*Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to [www.MyriadPro.com](http://www.MyriadPro.com)

## Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only:

Patient offered hereditary cancer genetic testing?  YES  NO  ACCEPTED  DECLINED

If YES, which test?  BRACAnalysis<sup>®</sup> with Myriad myRisk<sup>®</sup>  Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk

COLARIS<sup>®PLUS</sup> with Myriad myRisk  COLARIS AP<sup>®PLUS</sup> with Myriad myRisk  Single Site Testing  Myriad myRisk Update  Other: \_\_\_\_\_

Follow-up appointment scheduled:  YES  NO Date of Next Appointment: \_\_\_\_\_

Myriad Genetic Laboratories, Inc. \* 320 Wakara Way, Salt Lake City, Utah 84108 \* 800-469-7423 \* [www.MyriadPro.com](http://www.MyriadPro.com)

Myriad, the Myriad logo, BRACAnalysis, COLARIS, COLARIS AP, MELARIS, Myriad myRisk and the Myriad myRisk logo are either trademarks or registered trademarks of Myriad Genetics, Inc., in the United States and other jurisdictions. ©2016, Myriad Genetic Laboratories, Inc.

MGMRRFCFHQ 04/16