Cancer Risk Assessment Questionnaire

Patient Name _____ Date of Birth ____/____/____ Date Completed ____/____/____

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to YOU and/or YOUR FAMILY (consider all relatives on both mother's and father's side). YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED. ***Mother, Father, Sister, Brother, Sons, Daughters, Hal/ Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins (IF MULTIPLE), Great Grandparents (IF MULTIPLE), Great Aunt/Uncle (IF MULTIPLE}***

TYPES OF CANCER			RELATIONSHIP TO FAMILY MEMBER w/ CANCER and AGE at DIAGNOSIS		
			SELF/ SIBLING	MOTHER or Relatives on MOTHERS's side	FATHER or Relatives on FATHER's side
		EXAMPLE:	Me 35 Sister 40	Aunt 35	Grandmother 75
y	N	Do you have a relative with Breast cancer **before** age 50?			
y	N	Two breast cancers; one must be **50 or younger** (must be on same side of family to qualify) Three or more breast cancers; they can be at **any age (must** be on same side of family to qualify)			
y	N	Do you have a relative with Ovarian cancer **at any** ?			
y	N	Do you have a relative with Male breast cancer **at any** ?			
y	N	Ashkenazi Jewish ancestry ***with*** breast or ovarian cancer in a ***family member*** **at any age?**			
y	N	Do you have a relative with Colon Cancer **before** Age 50?			
y	N	Do you have a relative with Endometrial Cancer **before** Age 50?			
y	N	Do you have **3 relatives** with Colon cancer or endometrial cancer **at any age** on the same side of the family??			
y	N	Do you have **Ten or more** lifetime colon polyps?			
y	N	Any other cancers?			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No ☐ Do Not Know

Patient signature: _____ Date: _____

For Office Use Only:

Patient offered testing ☐ Accepted ☐ Declined Reason for decline: _____

☐ Does Not Meet Criteria ☐ Sample Collected

Office Signature _____

TRINITY WOMEN'S HEALTH

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____
LAST FIRST

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME#: _____

CELL#: _____ **SSN#** (NEED FOR BILLING): _____ EMAIL: _____

RESPONSIBLE PARTY (IF MINOR): _____ RELATIONSHIP: _____

EMPLOYER: _____ CONTACT PERSON: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ WORK#: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: _____

PRIMARY CARE DOCTOR: _____ HOSPITAL: _____

SPOUSE INFORMATION

SPOUSE'S NAME: _____ DOB: _____
LAST FIRST

SPOUSE'S SSN#: _____ CELL#: _____

INSURANCE INFORMATION

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____
LAST FIRST

NAME OF PRIMARY INSURANCE: _____

SUBSCRIBER ID#: _____ SUBSCRIBER GROUP#: _____

NAME OF SECONDARY INSURANCE: _____

SUBSCRIBER ID#: _____ SUBSCRIBER GROUP#: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the physicians of Trinity Women's Health (Drs Calinisan, and/or Safie) for services rendered by them in person or under their supervision. I understand that I am **financially responsible for any balance not covered by my insurance.**

Patient Name /guardian (please print) _____

Patient Signature _____ **Date:** _____

PATIENT INTAKE

PATIENT NAME: _____ DOB: _____
LAST FIRST

LAST MENSTRUAL CYCLE: _____

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED **HEIGHT:** _____ **WT:** _____

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				ALZHEIMER'S		
HEPATITIS				OSTEOPOROSIS		
GERD / OTHER				ANXIETY /DEPRESSION		

OBSTETRIC HISTORY	#TOTAL PREGNANCY		#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 (1ST DAY TO 1ST DAY)		DURATION OF BLEEDING	
PAP TEST	DATE OF LAST TEST □ NORMAL □ABNORMAL		MAMMOGRAM	DATE OF LAST TEST □ NORMAL □ABNORMAL
SEXUALLY TRANSMITTED DISEASES	□ HERPES □ SYPHILIS □ CHLAMYDIA □GONORRHEA □ HIV/AIDS			
CONTRACEPTIVE HISTORY	CURRENT CONTRACEPTIVE			

SOCIAL HISTORY	SMOKING CIG/ DAY		#YEARS		ALCOHOL DRINKS/WEEK		

I DO YOU FEEL SAFE AT HOME ☐ YES NO ☐ | HISTORY OF ABUSE ☐ YES NO ☐

MEDICATIONS	**DOSE**	**ALLERGIES TO MEDICATION**	**REACTION**

SURGERY	**DATE**	**SURGERY**	**DATE**

REVIEW OF SYSTEMS **- PLEASE MARK (X) ALL THAT APPLY -**

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

TRINITY WOMEN'S HEALTH OFFICE POLICIES

Your appointment will be rescheduled if you arrive more than 15 minutes late to your scheduled appointment time.

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 it 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**. That includes same day cancellations. Please contact us as soon as possible to cancel your appointment.

PHARMACY INFORMATION

To facilitate your prescription orders and refills, we encourage you to use our preferred pharmacy, Rancho Springs Outpatient Pharmacy, conveniently located downstairs in Suite #110. Most insurance plans are accepted. The pharmacy can also transfer out your prescription to your preferred pharmacy**. Free delivery and free mail order options are available.**

Rancho Springs Outpatient Pharmacy Phone 951-698-4505 Fax 951-698-4506
25485 Medical Center Dr., Ste #110 - Hours M-F 8:30am- 5:00pm
Murrieta, CA 92562

☐ By checking this box I acknowledge that I do not wish to use the preferred pharmacy and will choose my own pharmacy.

Alternate Choice #1:

_____

Name of Pharmacy Address Phone Number

Alternate Choice #2:

_____

Name of Pharmacy Address Phone Number

PATIENT CONSENTS

PLEASE INITIAL SPACE 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 that 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 that 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 and surgical purposes ONL**Y. _____
- I acknowledge the HIPAA (privacy practices notice) is available to print online or available on request. _____
- **I acknowledge that my insurance may be billed for any records reviewed _____.**
- **I acknowledge that any telephone calls to Trinity Women's Healthcare providers may be subject to telemedicine charge through my insurance**._____.
- 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: _____

ZERO Tolerance policy: Trinity Women's Health adheres to a zero-tolerance policy and has the right to terminate a relationship with any patient who's abusive (including yelling or threatening physicians, staff, or others), who fails to follow directions or who does not pay for/make arrangements to pay for services. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice. Initial_____.

-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 polices 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 or 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 right 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.

FINANCIAL POLICIES

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