CARING FOR WOMEN, P.C.

NAME_____ DOB:_____

To better serve you, please answer the questions listed below. Thank you.

Ages 40 TO 49

As part of your exam you will have the following done:

Blood Pressure Check	Abdominal Exam
Height & Weight	Pelvic & Vaginal Exam
Thyroid Exam	Pap Smear
Breast Check	Urinalysis (If Indicated)
Oral Cavity Exam	Hemocult Test (check for blood in stool)

Laboratory tests recommended for your age group:

CBC (complete blood count, test for anemia)
Coronary Risk Panel (Cholesterol Panel- every 5 years if normal)
TSH (Thyroid)
Chemistry Panel (Liver and Kidney Funtions)

Vaccines Recommended For Your Age Group: (Although we recommend these vaccines they are not available in our office)

Tetanus Vaccine (every 10 years)
Polio Vaccination (if not given as a child)
Influenza Vaccine (Annually)

*** Other tests :**
Mammogram (baseline at age 40 then every 2 years)

If you have a primary care physician please indicate below.

_____

Do you exercise regularly? _____YES _____NO
How Often?_____

If you, or anyone in your home are being hit or abused we highly encourage you to discuss this with your physician, We are here for you.

BILLING
If you have no medical problems, this appointment will be billed as a "Well Check". It is your responsibility to know if your insurance will pay for "Well Checks" and if you have met your deductible. If your insurance does not cover this appointment, you will be responsible for the payment.

Signature:_____ Date:_____

CARING FOR WOMEN

You are being seen today for a **Women's Well Check** (annual). A **Well Check** means you have no medical problems. It must therefore be billed as preventative medicine, whether or not your insurance pays for preventative medicine. It will be billed, as such, to your insurance company. To do otherwise is considered insurance fraud.

If you are having medical problems, this visit will be billed as a "Problem Focused" office visit even if she does a complete physical also. If you are having a medical problem that takes precedence over a well check, the doctor may see you for that condition today and bring you back for your well check at a later date. The appointment then would be billed as an office visit, even though you scheduled it as an annual. Those decisions are at the discretion of the medical provider. To bill it any other way is considered fraud.

Each insurance contract is different. It is your responsibility to know what your insurance company will pay for preventative medicine. If you **do not** know what your insurance pays, you may use the phone to call them or you may pay, in full, for the visit today. We will still bill your insurance for you. If they do pay for this visit, we will gladly refund it to you.

If your insurance company requires that you use a particular lab, it is your responsibility to remind us each time, otherwise we will use our usual labs. We cannot know what your particular policy requires, therefore need your help. Remember that the labs will bill separately and any questions on their billing should be directed to them.

I have read and understand the payment conditions of my well check.

Patient signature: _____

Date: _____

Any specific concerns you wish to discuss with your healthcare provider today?

_____

_____

_____

_____

CARING FOR WOMEN, P.C.
Pap Smear Consent Form

If your insurance requires that you use a specific lab, be sure to let us know each time.

Please send my pap to my insurance preferred lab which is: Quest _____
Lab Corp_____
Ak. Regional Lab _____
Prov. Hosp. _____

****In the event of an abnormal pap result, further testing may be ordered from the same pap sampling. There may be an additional cost to you for the test.**

_____ I agree to further testing if my pap results are abnormal.

Patient Signature _____ **Date** _____

CARING FOR WOMEN
Complete Women's Care

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Caring for Women P.C. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I **do not** authorize Caring for Women P.C. to release any or all information concerning my medical care to any individual except as set forth above.

_____I **authorize** Caring for Women P.C. to verbally release any or all information concerning my medical care to the following individuals.

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Patient Signature	Date

_____	_____	_____
Print Patient Name	Date of Birth	Social Security #

_____	_____
Office Witness Signature	*Date*

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Height: _____ **Weight:** _____ **Age of First Period:** _____ **Age of First Child (if applicable):** _____
Are You Menopausal: Yes or No **Have you ever used Hormone Replacement Therapy?** Yes or No
Has anyone in your family had genetic testing for a hereditary cancer syndrome (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65 yrs*
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish descent?				

COLON AND UTERINE CANCER (Colonic)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate Cancer (BRCA)				
Y	N	Pancreatic Cancer (Col/BRCA)				
Y	N	Melanoma (BRCA)				
Y	N	Other Cancers				

Patient's Signature: _____ **Date:** _____

For Office Use Only:
BRCA/Lynch Testing Indicated?: YES NO
Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED
Follow-up appointment scheduled: YES NO Date of Appointment: _____

Provider Signature: _____ Date: _____

BRCA – Personal or Fam. History

One person with (out to 2nd degree)
- Breast Cancer at 45 or younger
- Ovarian Cancer at any age
- Male breast cancer any age
- Breast Cancer + Jewish Heritage
- Bilateral Breast at 50 or younger
- Triple Neg Br.Ca. at 60 or younger

BRCA – Personal or Fam. History

Two persons with (out to 3rd Degree)
- 2 Breast Cancers (one at 50 or younger, 1 @any age)
- Breast & Ovarian (any age)

Three Persons with (out to 3rd degree)
- Breast and/or Ovarian and/or Pancreatic and/or Aggressive Prostate (any age)

Lynch Syndrome (Colon/Endo)

Personally affected with
- Colon or Endometrial at <50 or younger

Family History of Colon, Endometrial, + another Lynch Cancer
(gastric, ovarian, brain, kidney, small bowel)
- 2 or more Lynch cancers, 1 dx < 50
- 3 or more Lynch cancers, any age