Rosemary Delgado M.D.

2012

****** PLEASE NOTE ALL INFORMATION IS REQUIRED******

Name_____
Last First Middle

Mailing Address_____
Street Apt # City State Zip

Residence Address_____
(If Different) Street Apt # City State Zip

Home Phone_____ **Cell Phone**_____ **Other**_____

Birthdate_____ **Social Security Number**_____

Employer_____ **Occupation**_____

Emergency Contact_____
Name Relationship Phone

Primary Care Physician_____
Last Name, First Name Location Phone

Referring Physician_____
(If Different) Last Name, First Name Location Phone

INSURANCE WAIVER

If my insurance denies payment for any services not covered or not authorized, I am personally and fully responsible for payment.

Insurance Company_____

Subscriber Name_____ **Birthdate**_____

Social Security # _____ **Employer**_____

Secondary Insurance ? YES / NO Insurance Company_____

Subscriber Name_____ **Birthdate**_____

Social Security #_____

*****OFFICE POLICY*****

$25.00 No show / same day cancellation fee.
$10.00 Per each disability form . Please Allow 7-10 business days for completion of forms
$10.00 charge will apply for co-pays not made at time of appointment

I HAVE READ AND UNDERSTAND THE INSURANCE WAIVER AND OFFICE POLICY.

Patient Signature _____ **Date**_____

PATIENT QUESTIONNAIRE

NAME_____ DATE_____
AGE_____ FIRST DAY OF LAST MENSTRUAL PERIOD_____
MENSTRUAL FLOW [] HEAVY []REGULAR [] IRREGULAR [] PAINFUL
DAYS OF FLOW____ LENGTH OF CYCLES [] < 21 DAYS [] 24-31 DAYS [] >32 DAYS
[] PAIN/BLEEDING DURING OR AFTER INTERCOURSE
ARE YOU PREGNANT, OR DO YOU THINK YOU MAY BE PREGNANT?_____
ARE YOU NURSING?_____ DATE OF LAST PREGNANCY_____
WHAT METHOD OF BIRTH CONTROL DO YOU USE?_____
ARE YOU MENOPAUSAL?_____
DATE OF LAST PAP SMEAR_____ HISTORY OF ABNORMAL PAPS ?_____
DATE OF LAST MAMMOGRAM_____ HISTORY OF ABNORMAL MAMMOGRAMS?___
ANY FAMILY HISTORY OF BREAST CANCER?_____
TOTAL PREGNANCIES____ABORTIONS____MISCARRIAGES___BIRTHS_____
ANY ECTOPIC PREGNANCIES?_____
ARE YOU SEXUALLY ACTIVE?_____ MONOGAMOUS RELATIONSHIP?_____
NUMBER OF PARTNERS IN THE LAST YEAR?_____
DO YOU HAVE ANY QUESTIONS ABOUT YOUR SEXUALITY?_____
ANY SAFE SEX ISSUES?_____
ARE YOU CURRENTLY TAKING ANY MEDICATIONS?_____
_____.

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING ITEMS?

- ☐ LOCAL ANESTHISIA
- ☐ PENICILLIN
- ☐ SULFA DRUGS
- ☐ NARCOTICS (e.g. codeine)
- ☐ SEDATIVES
- ☐ IODINE
- ☐ ASPIRIN
- ☐ METALS (e.g. copper, nickel, etc.)
- ☐ LATEX
- ☐ ANY OTHER ALLERGIES_____

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERIES OR SERIOUS ILLNESS?_____
_____.

HABITS

- ☐ ALCOHOL TYPE_____ AMOUNT_____ PER DAY/MONTH
- ☐ DRUG USE: TYPE_____
- ☐ SMOKE : PACK PER DAY_____ FOR HOW LONG?_____
- ☐ CAFFEINE: HOW MUCH PER DAY?_____
- ☐ EXERCISE: TYPE_____ HOW OFTEN?_____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

NAME_____ DATE_____

DO YOU HAVE ANY OF THE FOLLOWING?

[]ABDOMINAL PAIN
[]ANEMIA
[]ANXIETY/DEPRESSION
[]ASTHMA
[]MENTAL ILLNESS
[]RHUEMATIC FEVER
[]SEXUAL DYSFUNCTION
[]PAINFUL URINATION
[]HEART MURMUR
[]PACEMAKER
[]HEPATITIS/JAUNDICE
[]MITRAL VALVE PROLAPSE
[]PNUEMONIA
[]STROKE
[]URINARY INCONTINENCE
[]VENEREAL DISEASE
[]TUBERCULOSIS
[]LIVER DISEASE
[]GLAUCOMA
[]CANCER
[]SEIZURES
[]FATIGUE
[]ALLERGIES/HAYFEVER
[]SWOLLEN ANKLES
[]ARTHRITIS/RHUEMATISM
[]LOSS OF APPETITE
[]BLEEDING PROBLEMS
[]BLOOD CLOTS
[]DIZZINESS/FAINTING
[]FREQUENT HEADACHES
[]HEART ATTACK
[]HEART DISEASE
[]KIDNEY DISEASE
[]CHANGE IN BOWEL HABITS
[]CHEST PAIN
[]DIABETES
[]VARICOSE VEINS
[]WEIGHT LOSS
[]AIDS/HIV
[]BACK PAIN
[]OSTEOPOROSIS
[]SKIN DISEASE
[]THYROID DISEASE
[]OTHER_____

DO YOU HAVE ANY FAMILY HISTORY OF THE FOLLOWING?

[]ALCOHOLISM	[]ASTHMA	[]BLEEDING DISORDERS
[]CANCER	[]DIABETES	[]HEART DISEASE
[]EPILEPSY	[]STROKE	[]HIGH BLOOD PRESSURE
[]MIGRAINES	[]KIDNEY DISEASE	[]THYROID DISEASE
[]MENTAL ILLNESS	[]OSTEOPOROSIS	[]BLOOD CLOTS

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

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

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	*none*	—	*Brother*	*36 yrs*	*Aunt* *Cousin*	*44 yrs* *58 yrs*	*Grandfather*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.myriadtests.com

MYRIAD®

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED TO DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY,

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Disclosure of Protected Health Information:

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This included the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health care information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may also call you by your name in the waiting

Acknowledgement of Receipt of Notice of HIPPA Privacy Practice

Rosemary Delgado M.D.
240 La Casa Via Suite#100
Walnut Creek, CA 9459
(925) 937-9345

I herby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of any amended notice at each appointment.
By listing someone other then yourself below. You are giving us the legal right to discuss your medical information with the person you list.

Signature:_____ Date:_____

Print Name:_____ Telephone:_____

Relationship: (Circle your relationship to our patient)

* Parent of guardian of minor patient

* Guardian or conservator of incompetent patient

* Beneficiary or personal representative of deceased patient

Name of Patient_____