

Patient Information Sheet

Patient Name

Social Security #

Street Address

City, State & Zip code

Home Phone

Cell Phone

Work Phone

Email Address

Pharmacy Address/Phone:

Patient Employer

Address

Spouse Information

Spouse Name

Spouse Date of Birth

Spouse Social Security #

Spouse Employer

Spouse Address (if different)

Spouse Cell Phone

Spouse Work Phone

Emergency Contact Information

IN CASE OF EMERGENCY, NOTIFY:

Emergency Name (other than spouse)

Emergency Contact Address

Emergency Contact Phone

Referral

Who may we thank for your referral?

Insurance Information

Insurance Information Payment is requested at the time of service, unless prior arrangements have been made

Insurance Company

Name of Primary Insured

Authorization to Release Information and Assignment of Benefits

- By checking the box on the left, I certify that information I have reported about my insurance is correct.
- By checking the box on the left, I authorize the release of any medical information necessary to process this claim.
- By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment from my insurance company be made directly to my doctor or to the party who accepts assignment.
- By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.
- By checking the box on the left, I understand that I am financially responsible for the charges not covered by my insurance.

Signature

Date

Constitutional

- Yes No Chills
- Yes No Fatigue
- Yes No Fever
- Yes No Night Sweats
- Yes No Victim-Domestic Violence
- Yes No Weight Gain (unintentional)
- Yes No Weight Loss (unintentional)

Eyes

- Yes No Eye Pain
- Yes No Glasses/Contact

Ears/Nose/Throat

- Yes No Ear Pain
- Yes No Frequent Nose Bleeds
- Yes No Bleeding Gums
- Yes No Oral Gum Disease
- Yes No Dentures Present

Cardiovascular

- Yes No Chest Pain
- Yes No Dizziness
- Yes No Heart Palpitations
- Yes No Racing Heartbeat

Respiratory

- Yes No Cough (acute)
- Yes No Cough (chronic)
- Yes No Shortness of Breath

Gastrointestinal

- Yes No Abdominal Pain
- Yes No Bloating
- Yes No Constipation
- Yes No Diarrhea
- Yes No Heartburn
- Yes No Black Stool
- Yes No Nausea
- Yes No Vomiting
- Yes No Stool Caliber Change

Genitourinary

- Yes No Painful Menstrual Cycle
- Yes No Pain With Intercourse
- Yes No Pain With Urination
- Yes No Genital Lesions
- Yes No Blood In Urine
- Yes No High Risk Sexual Behavior
- Yes No Irregular Menstrual Cycle
- Yes No Heavy Menstrual Cycles
- Yes No Frequent Awakening At Night to Urinate
- Yes No Post-Coital Vaginal Bleeding
- Yes No Post-Menopausal Bleeding
- Yes No Rape (history of)
- Yes No Sexual Abuse
- Yes No Urinary Incontinence
- Yes No Vaginal Discharge
- Yes No Vaginal Itch

Musculoskeletal

- Yes No Back Pain
- Yes No Muscle Pains

Integumentary/Breast

- Yes No Rashes
- Yes No Breast Mass
- Yes No Breast Skin Changes
- Yes No Breast Tenderness
- Yes No Nipple Discharge
- Yes No Self Breast Exams?

Neurological

- Yes No Dizziness
- Yes No Fainting
- Yes No Headaches
- Yes No Weakness

Hematologic /Lymphatic

- Yes No Easy Bruising
- Yes No Excessive Bleeding
- Yes No Hx of Blood Transfusion

Endocrine

- Yes No Hair Loss
- Yes No Heat/Cold Intolerance
- Yes No Excessive Facial or Body Hair
- Yes No Hot Flashes
- Yes No Infertility

Allergic/Immunologic

- Yes No Seasonal Allergies/"Hayfever"
- Yes No Perennial Allergies

Psychiatric

- Yes No Anxiety
- Yes No Crying Spells
- Yes No Depression
- Yes No Feeling Stressed
- Yes No Loss of Interest in Pleasurable Activities
- Yes No Mood Swings
- Yes No PMS
- Yes No Recreational Drug Use
- Yes No Sleep Disturbance
- Yes No Suicidal Thoughts



BHRT Checklist For Women

Patient Name _____

Date _____

Email Address _____

Symptom(s) (please check)

- | | | | | |
|--------------------------------|-------------------------------|-----------------------------------|---------------------------------|------------------------------|
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Depressive Mood |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Memory Loss |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Mental Confusion |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Decreased Sex Drive / Libido |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Sleep Problems |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Mood Changes / Irritability |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Tension |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Migraine / Severe Headaches |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Difficult To Climax Sexually |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Bloating |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Weight Gain |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Vaginal Dryness |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Hot Flashes |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Night Sweats |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Dry and Wrinkled Skin |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Hair is Falling Out |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Cold All The Time |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Swelling All Over The Body |
| <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | Joint Pain |

Family History

- | | | |
|------------------------------|-----------------------------|---------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Alzheimer’s Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast Cancer |

Family Cancer History Questionnaire

Patient Name

Date of Birth

Age

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, daughters, grandparents, 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)

Y/N	CANCER	YOU Age at Diagnosis	Parents Siblings Children	Age at Diagnosis	Maternal Relatives	Age at Diagnosis	Paternal Relatives	Age at Diagnosis
Y	Example: Breast Cancer	45	-----	-----	Aunt Cousin	45 61	Half-Sister	53
	Breast Cancer (Female or Male)							
	Ovarian Cancer							
	Uterine Cancer (Endometrial)							
	Colon/Rectal Cancer							
	10 or more Lifetime Colon Polyps (Specify #)							
	Other (Specify cancer type)							

- Yes No Are you of Ashkenazi Jewish descent?
- Yes No Are you concerned about personal and/or family history of cancer?
- Yes No Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
(Please explain/include a copy of result, if possible).

Acknowledgement for Consent to Use and Disclosure of Protected health Information (PHI)

Use and Disclose of your Protected Health Information (PHI)

Your Protected Health Information will be used by Dr. David Fong or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Please list others we may release your PHI to: _____

Please indicate below whether you agree to allow us to leave a detailed telephone message regarding your test results at any of the phone numbers you have listed.

Agree Deny

Patient Name

Date

Signature



Preventative Well Woman Exam

Based on American College of Obstetrics and Gynecology and insurance standards, preventative office visits are routine well patient evaluations. Preventative well woman exams consist of health history, medication history, a physical exam with breast exam, pap smear, bimanual uterine/ovary exam (as indicated), urinalysis, and routine blood work (as indicated).

If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this exam, you may be charged an additional fee/co-pay based on your insurance benefits. All visit information is sent electronically to your insurance company and you will be responsible for any additional fees as determined by your insurance benefits.

Patient Name

Date

Signature

General Consent for Treatment

General consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Dr. David Fong and his staff to conduct any diagnostic examinations, tests, and procedures deemed necessary in my care. I authorize the provision of any medications, treatment or therapy necessary to effectively assess and maintain my health or diagnose and treat my illness or injury. I understand that it is the responsibility of Dr. Fong to explain the rationale for diagnostic tests or procedures, the available treatment options, common risks and benefits or procedures, and alternative treatment options.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse and particular examination, test, procedure, treatment, therapy or medication recommended by Dr. Fong. I also understand that the practice of medicine is not an exact science and no guarantees have been made regarding the results of my evaluation and/or treatment.

Signature

Date

I understand that I choose to send correspondence such as family photographs or birth announcements to the office of Dr. David Fong, the photos contained in these items may be displayed in public areas in the office. I understand that I have the right to request the photographs be kept private and will include a request of privacy with the correspondence if privacy is desired.

Signature

Date

These consents remain active unless revoked in writing by patient or authorized representative.

**Cancellation Policy / No Show Policy
For Doctor Appointments and Surgery**

1. Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$50 fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand delays can happen; however, we must try to keep the other patients and Dr. Fong on time.

If a patient is 15 minutes past their scheduled time, we have the right to reschedule the appointment.

Similarly, we try our best to stay on schedule, although emergencies sometimes arise. If we are significantly delayed, or Dr. Fong needs to leave unexpectedly due to surgery or delivery, we will try to notify you beforehand. Please assist us by being on time for your appointment.

3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expense for the office. If surgery is not cancelled at least 10 days in advance, you will be charged a \$75 fee. This will not be covered by your insurance company.

4. Account Balances

We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

Patient Name

Signature

Date