Radiance OB-GYN

Registration Form

Patient Name:_____

☐ Female ☐ Male Date of birth_____

Social Security #_____ Email_____

Address: _____ Apt / Unit _____

City _____ State_____ Zip Code_____

Mobile phone: _____ Home phone: _____

Consent to text (appointment reminders, test results, etc.) ☐ Yes ☐ No

Preferred method of communication (circle one): mobile phone / home phone / email

Would you like Portal access? ☐ Yes ☐ No

Demographics

Language: ☐ English ☐ Spanish ☐ Japanese ☐ other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Race: ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Decline to specify

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you hear about us? ☐ advertising ☐ primary care ☐ specialist physician

☐ patient in practice ☐ hospital ☐ insurance company

Can we access you **Medication History** directly from pharmacy benefits manager? ☐ Yes ☐ No

PHARMACY: _____ PHONE: _____

Preferred lab:_____Imaging:_____

Emergency Contact

Name: _____ Phone Number:_____

Relationship: Spouse, partner, parent, friend, other_____

Employment

Employer Name: _____

Employer Phone Number: _____

Usual occupation (current or most recent): _____

Usual Industry: _____

Insurance

Primary Insurance: _____ ID#_____

Group Name: _____ Group #_____

Subscribers Name:_____ Date of Birth:_____

Secondary Insurance:_____ ID#_____

Group Name:_____ Group #_____

Subscribers Name:_____ Date of Birth:_____

Primary / Referring Physician

Primary Care Physician:_____

Referring
Physician:_____

I certify that I have read and agree to Radiance OB/GYN payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Radiance OB/GYN all money to which I am entitled for medical expenses related to the services performed from time to time by Radiance OB/GYN, but not to exceed my indebtedness to Radiance OB/GYN. I authorize Radiance OB/GYN to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 120 days of notification of the amount due will result in submission to an outside collection agency. A $10.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Radiance OB/GYN by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Radiance OB/GYN. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Signature Date / Time

Radiance OB-GYN
Women's Health Is Our Passion

New Patient Intake Form

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Medication Allergies: include any reactions ☐ NKDA

_____

_____

Food Allergies:

_____

_____

Current medications, dosage and frequency (use back or separate page if necessary):

_____

_____

Vaccines: Have you received: Gardasil vaccine? ☐ Yes (3 doses) ☐ Yes (< 3 doses) ☐ No

Influenza vaccine? ☐ Yes ☐ No Tdap/Tetanus/Whooping Cough ☐ Yes ☐ No

Medical Problems

Chief Complaint (reason for the visit): _____

List any ongoing medical problems (Gynecological or other): _____

_____

_____

Gynecological History

Are you sexually active: ☐ yes ☐ No Current Method of birth Control? _____

First day of your last menstrual period? _____ Date of last Pap? _____

Have you EVER had an abnormal Pap? ☐ Yes ☐ No Details: _____

Have you had treatment due to an abnormal Pap? ☐ Yes ☐ No If Yes, indicate when: _____

Have you ever had an STD/STI (disease/infection) ? _____

History of ☐ colposcopy or ☐ LEEP or ☐ cryoablation Dates: _____

Age at first menses: _____ Most recent bone density: _____ Most recent Mammogram: _____

Date of last Colonoscopy: _____ Duration of flow (days): _____ Menses monthly? Y / N

Flow: ☐ Light ☐ Moderate ☐ Heavy Cycle frequency (Q days): _____

Hormone replacement therapy? ☐ Yes ☐ No Age at menopause: _____

Obstetric History (Please fill in the blanks with details or check appropriate boxes)

_____ Total number of pregnancies _____ Full term
_____ Premature _____ Abortions Elective
_____ Abortions Spontaneous (miscarriages_ _____ Ectopic pregnancies
_____ Multiple births _____ Total living children

Pregnancy #1
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Delivery: ☐ Full term (> 36 wks) ☐ Vaginal ☐Cesarean section
☐ Preterm Delivery (< 36 wks) ☐ Vaginal ☐Cesarean section
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____
Elective termination of pregnancy ☐ Yes ☐ No How many weeks pregnant_____
Spontaneous abortion ☐ Yes ☐ No How many weeks pregnant _____ D &C? ☐ Yes ☐ No
Pregnancy #2
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Delivery: ☐ Full term (> 36 wks) ☐ Vaginal ☐Cesarean section
☐ Preterm Delivery (< 36 wks) ☐ Vaginal ☐Cesarean section
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____
Elective termination of pregnancy ☐ Yes ☐ No How many weeks pregnant_____
Spontaneous abortion ☐ Yes ☐ No How many weeks pregnant _____ D &C? ☐ Yes ☐ No
Pregnancy #3
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Delivery: ☐ Full term (> 36 wks) ☐ Vaginal ☐Cesarean section
☐ Preterm Delivery (< 36 wks) ☐ Vaginal ☐Cesarean section
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____
Elective termination of pregnancy ☐ Yes ☐ No How many weeks pregnant_____
Spontaneous abortion ☐ Yes ☐ No How many weeks pregnant _____ D &C? ☐ Yes ☐ No
Pregnancy #4
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Delivery: ☐ Full term (> 36 wks) ☐ Vaginal ☐Cesarean section
☐ Preterm Delivery (< 36 wks) ☐ Vaginal ☐Cesarean section
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____
Elective termination of pregnancy ☐ Yes ☐ No How many weeks pregnant_____
Spontaneous abortion ☐ Yes ☐ No How many weeks pregnant _____ D &C? ☐ Yes ☐ No
Pregnancy #5
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Delivery: ☐ Full term (> 36 wks) ☐ Vaginal ☐Cesarean section
☐ Preterm Delivery (< 36 wks) ☐ Vaginal ☐Cesarean section
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____
Elective termination of pregnancy ☐ Yes ☐ No How many weeks pregnant_____
Spontaneous abortion ☐ Yes ☐ No How many weeks pregnant _____ D &C? ☐ Yes ☐ No
Pregnancy #6
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Delivery: ☐ Full term (> 36 wks) ☐ Vaginal ☐Cesarean section
☐ Preterm Delivery (< 36 wks) ☐ Vaginal ☐Cesarean section
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____
Elective termination of pregnancy ☐ Yes ☐ No How many weeks pregnant_____
Spontaneous abortion ☐ Yes ☐ No How many weeks pregnant _____ D &C? ☐ Yes ☐ No

Prior pregnancy complications:

_____

_____

_____

Social History

TOBACCO USE: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker ☐ Chew Tobacco

Years of Smoking _____ # of Packs _____

ALCOHOL USE: ☐ None ☐ Occasionally ☐ Moderate ☐ Heavy **Type:** Wine, Beer, Hard Liquor

DRUG USE: ☐ Current ☐ Past ☐ None Years of usage _____

Type: THC/marijuana, cocaine, IV drugs, other. Details:_____

OCCUPATION: _____

List any current or prior hazardous work exposures: _____

Diet: ☐ Healthy ☐ Diabetic ☐ High Carbs ☐ Vegetarian ☐ Vegan

Are you Jehovah's witness? ☐ Yes ☐ No

Surgical History

Past Surgical History (please indicate date of surgery)

____Hysterectomy (removal of uterus +/ - cervix)

____ Through large abdominal incision only

____ Through small, laparoscopic incision only

____ Through vagina alone

____Combined laparoscopic / vaginal approach

____ One or both tubes and ovaries removed

____Bladder lift (anterior colporrhaphy) ____ check here if with mesh

____ Correction rectal prolapse (posterior colporrhaphy) ____ check here if with mesh

____Urethral Sling (TOT or TVT)

____ Breast implants: (please circle) saline or silicone ____ Breast reduction

____ Mastectomy; give details _____

____ Cholecystectomy (removal of gallbladder)

____ Appendectomy (removal of appendix)

____ Thyroidectomy (removal of thyroid gland: (please circle) partial or complete

Please list any other surgeries and dates:

_____

_____

_____

Past Medical History

Personal & Family - Have you or any of your relatives **ever** had the following:

***Include age of diagnosis.**

	Self	Mother	Father	Brother	Sister	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Son/Daughter	Son/Daughter	Other	Other
Alcohol Abuse													
Alzheimer's Disease / Dementia													
Asthma													
***Breast Cancer**													
Cancer (type:_____)													
Chronic Liver Disease &/or Hepatitis													
Chronic Obstructive Pulmonary Disease													
Cirrhosis													
***Colon Cancer**													
Congestive Heart Failure													
Depression / Anxiety													
Diabetes													
Dialysis													
Emphysema													
***Heart Attack**													
High Cholesterol													
HIV Infection													
Hypertension													
Kidney Disease / Stone / Infections													
Mental Illness													
Osteoporosis													
***Ovarian Cancer**													
Parkinson's Disease													
Prostate Cancer													
Seizures													
Sexually Transmitted Disease													
Stroke													
Tuberculosis													
Other:_____													
Other:_____													

Radiance OB-GYN
Women's Health Focused

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name (if applicable): _____ Social Security #: _____

I hereby request and authorize (name of current health care facility) _____ to release health care information of the patient named above to:

Radiance OB-GYN
3998 Vista Way
Suite C
Oceanside, CA 92056

Tel: 760-385-8008
Fax: 760-305-8068

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information pertaining to the following treatment, condition, or dates:

_____

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 *et seq.*, includes herpes simplex virus, human papilloma virus, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results and HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature: _____ Date: _____

Guardian signature (if patient is minor): _____ Date: _____

Name of Guardian (Print): _____ Relationship to patient: _____

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F):_____ **Today's Date(MM/DD/YY):**_____ **Health Care 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
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	*------*	*---*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ 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)*

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

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

‡In the same individual or on the same side of the family

§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Lynch Syndrome - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*

^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

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

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____