



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 your **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



New Patient Intake Form

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Medication Allergies: include any reactions

NKDA (no known drug allergies)

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, (date) _____ No

Tdap/Tetanus/Whooping Cough Yes, (date) _____ No

Medical Problems

Chief Complaint (reason for the visit): _____

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

Social History

TOBACCO USE: Current Smoker Former Smoker Never Smoker Chew Tobacco

Years of Smoking _____ # of Packs _____

ALCOHOL USE: None Occasional 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: Regular Diabetic High Carb Vegetarian Vegan Gluten free

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:

Gynecological History

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

First day of your last menstrual period? _____

Date of last Pap? _____ Results of last Pap: Normal Pap smear Negative HPV

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 of 1st period: _____ 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

_____ Ectopic pregnancies

_____ Abortions Spontaneous (miscarriages)

_____ Multiple births (eg. twins)

_____ Total living children

Pregnancy #1

Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex Male Female

Delivery: Full term (> 36 wks) 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) 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) 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) 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) 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) 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: (examples: gestational diabetes, pre-term labor, preeclampsia)

New Obstetric Episode

Number of fetuses: _____ Pre-pregnancy Weight: _____

Father of the Baby Name: _____ Phone: _____

Pediatrician: _____

Menstrual History

Last menstrual period: _____ Definite: Yes No

Menses monthly: Yes No Frequency: every _____ days

Age at first menses: _____ On birth control at conception: Yes No

Genetic Screening and Infection History (Personal or Family History, Patient or Father of Baby)

Mother will be 35 years or older at Estimated Date of Delivery? Yes No

Thalassemia (Italian, Greek, Mediterranean, or Asian Background) Yes No

Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly) Yes No

Congenital Heart Defect Yes No

Down Syndrome Yes No

- Tay-Sachs (eg. Jewish, Cajun, French-Canadian) Yes No
- Canavan Disease Yes No
- Sickle Cell Disease or Trait (African) Yes No
- Hemophilia or Other Blood Disorders Yes No
- Muscular Dystrophy Yes No
- Cystic Fibrosis Yes No
- Huntington's Chorea Yes No
- Mental Retardation/Autism Yes No
- If Yes, Was Person Tested For Fragile X? Yes No
- Other Inherited Genetic Or Chromosomal Disorder: _____ Yes No
- Maternal Metabolic disorder (eg. Type 1 Diabetes, PKU) Yes No
- Patient or baby's father had a child with birth defects not listed above? Yes No
- Recurrent Pregnancy loss, or a stillbirth Yes No
- Any Other Genetic History: _____ Yes No
- Live with someone with TB or Exposed to TB Yes No
- Patient or partner has a history of genital herpes Yes No
- Rash or viral illness since last menstrual period Yes No
- Prior GBS-infected child Yes No
- History of STD, Gonorrhea, Chlamydia, HPV, Syphilis Yes No
- History of HIV Yes No
- History of Hepatitis Yes No
- Other infection history: _____ Yes No
- Hemoglobinopathy or Carrier Yes No
- Other Structural birth defect: _____ Yes No
- Recent travel outside of country Yes No

Signature: _____ Date/Time: _____



**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 Tel: 760-385-8008
3998 Vista Way Fax: 760-305-8068
Suite C
Oceanside, CA 92056

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
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE: BREAST CANCER	45	---	---	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER (Female or Male)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE (ENDOMETRIAL) CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME COLON POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> 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: _____

