STATESBORO WOMEN'S HEALTH SPECIALISTS

Gary B. Sullivan, MD, FACOG Lisa S. Rogers, MD, FACOG Barbara B. Williams, DO, FACOG
1523 Fair Road/ PO Box 1958, Statesboro, GA 30459 Phone: 912-871-2000 Fax: 912-871-2500

Patient Registration

Patient: _____ Today's Date: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Work#: _____ Cell #: _____
Email: _____ Drivers License State: _____ Number: _____
Race: _____ Religion: _____ Preferred Communication: __Email __Patient __Portal __Phone __Text
Marital Status: __Single Married __Partnered __Widowed __Separated __Divorce
Primary Physician: _____ Preferred Pharmacy: _____

Patient's Information

Name: _____
Birthday: _____
Social Security #: _____
Employer: _____
Occupation: _____
Work #: _____

Spouse's Information

Name: _____
Birthday: _____
Social Security #: _____
Employer: _____
Occupation: _____
Work #: _____

Person Responsible for the Bill

Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Occupation: _____
Work #: _____ Primary #: _____

Insurance Information

Primary Insurance: _____
Subscriber's Name: _____
Patient's Relationship: Self:__ Spouse: __other: __
Social Security #: _____
Subscriber's Birthday: _____
Subscriber's Employer: _____
Group #: _____ ID#: _____

Secondary Insurance: _____
Subscriber's Name: _____
Patient's Relationship: Self: __ Spouse: __ other: __
Social Security #: _____
Subscriber's Birthday: _____
Subscriber's Employer: _____
Group #: _____ ID#: _____

Other information

***In case of emergency, local friend or relative to be notified (not living at the same address):
Name: _____ Relationship to the Patient: _____
Home #: _____ Work#: _____ Cell #: _____

Assignment and Release: I hereby authorize my insurance and/or government benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information, including medical records, required to obtain payment.

Signed: _____ Date: ____/____/____

STATESBORO WOMEN'S HEALTH SPECIALISTS

Please mark which Doctor you prefer to see.

___Gary B. Sullivan, MD, FACOG ___Lisa S. Rogers, MD, FACOG ___Barbara B. Williams, DO, FACOG

Type if Insurance:_____ Type of Appointment:_____

Mail or fax to: PO Box 1958, Statesboro, GA 30459 Phone: 912-871-2000 Fax: 912-871-2500

RELEASE AND/OR OBTAIN MEDICAL INFORMATION AUTHORIZATION

Patient name: _____ DOB:____/____/____
SSN: _____ Maiden name (if applicable):_____
Patient contact number - Home: _____Work: _____Cell:_____

1. I give my permission for Statesboro Women's Health Specialists:
_____To release medical information to: _____To obtain medical information from:

Name of Facility:_____
Address: _____
Phone: _____Fax: _____
Specific information (if applicable): _____

2. I consent only to the release of information specifically name about and only to the specific person or agency named above.
3. I understand that I may withdraw my permission for the use of this information at any time except to the extent that it has already been used as previously authorized to take action on my behalf. In all cases, any consent given hereby shall have a duration no longer than that reasonably necessary to effectuate the purpose for which said consent is given. If I do not later withdraw this permission, it is my understanding that it will automatically expire in (60) days from the date of signature.
4. I am aware and specifically waive any privilege regarding the following information, which may or may not be contained in these records:

a) Communication made by me to a Psychiatrist (O.C.G.A. section 24-9-21).
b) Communication made by me to a Licensed Applied Psychologist (O.C.G.A. section 43-39-16).
c) Medical information concerning drug dependency (O.C.G.A. section 25-5-17).
d) Medical information concerning alcohol and drug dependency (O.C.G.A. section 37-7-166).
e) Medical information concerning mental retardation (O.C.G.A. section 37-4-125).
f) Medical information concerning alcohol and drug abuse (42CFR, part 2).
g) Medical information concerning Acquired Immune Deficiency Syndrome (AIDS).

Patient/Authorized Person Signature: _____ Date: ____/____/____

Relationship of Authorized Person: _____ Witness Signature: _____

The information released per this authorization has been disclosed from records protected by State and Federal confidentiality statutes. These statutes prohibit further disclosure of this information without the specific written consent of the patient.

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Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal law, and outlining my rights regarding my health information.

Signed : _____ Date: _____

Relationship to patient (if not signed by Patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____

_____

_____

_____

Internal Use Only

If patient or representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on: _____ : _____ Time: _____

By (name & title): _____

STATESBORO WOMEN'S HEALTH SPECIALIST

Financial Policies

Please place your initials by each of the statements below to designate that you have read and understand the financial policies of this practice.

_____ For your convenience, we have an in-house laboratory service. LabCorp is the laboratory the providers prefer to utilize. With LabCorp, they accept, and bill all insurances. I understand that I am responsible for notifying Statesboro Women's Health Specialists if I need my blood work or cultures sent to a different lab.

_____ I understand that I am responsible for determining if Statesboro Women's Health Specialists is a participating provider with the network affiliated with my insurance company. I am aware that if Statesboro Women's Health Specialists is an out-of-network facility, I may be responsible for greater out-of-pocket expense.

_____ I understand that I am responsible for payment of my co-pays up front. I understand that I am also responsible for any deductibles/co-insurance on services rendered. For surgical procedures, deductibles and facility fees must be paid in full at time of service.

_____ I agree to make regular monthly payments on any balances or risk my account being transferred to a collection agency. Account balances not paid within 3 months will be subject to added monthly interest fees. If my account is transferred to an outside collection agency, I am aware that there will be additional collection fees of 33% of the total balance added to my amount due.

_____ I understand that it is my responsibility to provide **ALL** of my insurance information at the time services are rendered. If claims are denied due to being past the filing time limit or if charges are denied by a secondary plan for failure to provide primary insurance information timely, I will be responsible **in full** for the charges incurred.

_____ I understand that there is a $25.00 fee associated with completion of FMLA/disability forms for the patient. Each set of forms would require the $25.00 payment. There is a $50.00 fee associated with the completion of FMLA/disability form for family members. Each set of forms would require the $50.00 payment. This fee is not covered by any insurance and will be patient responsibility. The fee will need to be paid prior to the completion of any forms

_____ I understand there is $25.00 fee for copying medical records if the records are not being sent to another provider.

_____ I understand that there will be a $50.00 fee associated with appointments that are cancelled with less than 24-hour notice. This fee is not covered by any insurances and will be patient responsibility. The fee will need to be paid prior to the rescheduling of the appointment.

_____ _____

Patient/Responsible Party signature Date

STATESBORO WOMEN'S HEALTH SPECIALISTS

Practice Policies

Appointment Policies

- All appointments are scheduled in advance. We do not allow walk-ins. Same day problem appointments are almost always available.
- Please be on time. If you are 15 minutes late, your appointment is subject to be rescheduled.
- Please call if you cannot keep your appointment. Recurrent missed appointments are grounds for dismissal from our practice.
- Physician, office, and patient emergencies impact schedules and result in unpredictable waiting times. We make every effort to maintain our schedule and minimize any inconvenience to you. However, emergencies do occur. If a significant delay occurs, we will inform you and we will gladly reschedule your appointment if you would prefer not to wait.
- Patients are taken back in the order of the appointment time, not the arrival time. Also, some patients may be scheduled for multiple tests so they may be taken back in a different order.

Professional Policy

- Our staff strives to be courteous at all times. If you feel you have received poor customer service, please notify the Office Manager.
- Being rude or threatening to our staff is grounds for dismissal from the practice.
- Please be courteous and not use your cell phone while in our practice. Cell phones interfere with the functioning of certain equipment and may contribute to delays.

Prescription and Forms

- For prescription refills, please call your pharmacy and they will contact us. Please allow 3 days from the date of request. We will only notify you if there is a problem with your request.
- Please allow up to one week for completion of disability forms. There is a $25.00 charge for this service and must be paid when you pick up the forms.
- There is a fee of up to $0.97 per page for copying medical records in their entirety. This must be paid in advance.
- Our physicians rarely call in medications. We believe that by seeing you in the office, we can provide better care.

Expectations and Behaviors

- You are responsible for the behavior of all guests you bring to our office, including your children.
- Children should not be left unattended in the waiting room or exam room.
- Children should not play on or with the furniture.
- Drinks and food are not allowed in our office.

Phone Call Policy

- Our physicians are available for urgent medical matters after office hours.
- Please do not call us regarding refills, forms, billing, etc after hours.
- When you call the office for medical advice, a nurse will call you back or forward a message to one of our physicians. These calls are handled in order of medical importance first. If you do not want to wait for a call back, we suggest you schedule an appointment for us to see you. We handle these calls as quickly as possible, however, it may take up to 24 hours for a nurse to return your call.

Ultrasounds

- Ultrasounds are performed for medical necessity. In pregnancy, we generally perform 3 routine ultrasounds:
  8-10 weeks---dates
  18-20 weeks---anatomy
  34-36 weeks—"estimated fetal weight
- We offer a free 4D ultrasound at 24-26 weeks. The 4D ultrasound is scheduled during your GTT (Glucose Tolerance Test) appointment. There is no charge for this service but it is only attempted ONCE.
- Any ultrasounds that are not medically necessary but are requested by the patient (such as for sex check or another 4D) will incur a fee. For a sex check ultrasound the fee is $175.00 For a 4D ultrasound the fee is $175.00 These fees must be paid in full prior to the ultrasound being performed.

Referrals

- Occasionally we do refer our patients to other physicians. We make every effort to accomplish this in a timely manner. If you have not been notified about your referral appointment within one week, please contact our office.

I agree to adhere to the above financial and office policies. By signing below, I accept the terms and conditions of these policies.

_____ _____

Patient/Responsible Party Signature Date

Statesboro Women's Health Specialists Privacy Practices

Notice of Privacy Practices Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise To You, Our Patients

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of Statesboro Women's Health Specialists, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Statesboro Women's Heath Specialists, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged to improve the health of the state and nation
- Source of data for our planning and marketing
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve
- Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Statesboro Women's Health Specialists, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request
- Inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law)
- Amend your health record as provided by 45 CFR 164.526
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528
- Request confidential communications of your health information as provided by 45 CFR 164.522 (b)
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (a) (however, we are not required by law to agree to a requested restriction)

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate your health information. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-handed corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508 (b) (5), except to the extent that action has already been taken.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer, Mary Collins, at 912-871-2000.

If you believe your privacy rights have been violated, you can either file a complaint with Mary Collins, or with the Office for Civil Rights, US. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Georgia is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3870
61 Forsyth Street, SW.
Atlanta, GA 30303—8909

Examples of Disclosure for Treatment, Payment, and Health Operations

We will use your health information for treatment. We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment. We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:

If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

We will use your health information for regular health operations.

We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to run our practice and support the core functions. *For example:*

Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

Appointment Reminders

We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

Decedents

Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

Worker's Compensation

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Research

We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who reviewed the research proposal.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of donation and transplant.

As Required By Law

We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulations and civil rights laws.

Specialized Government Functions

We may disclose health information for military and veterans affairs or national security and intelligence activities.

Business Associates

There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Practice Marketing

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (e.g., to notify you of any new tests or services we may be offering).

Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Personal Representative

We may disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

To Avert A Serious Threat To Health/Safety

We may disclose information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

Communication With Family

Unless you object, health professionals may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

Disaster Relief

Unless you object, we may disclose your health information to an organization assisting in a disaster relief. For all non-routine operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

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New Patient Medical History (New or not seen in the last 12 months) Today's Date: ____/____/____

Name: _____ Birthday: ____/____/____ Age: ____

Reason for Visit: _____ Weight: _____

_____ Height: _____

Past Medical and Surgical History

Have you ever had the following: ***Primary/Local Physician:* _____

YES	ILLNESS	DATE OF ONSET	YES	ILLNESS	DATE OF ONSET
	Anemia			Gastric Reflux(GERD)/Ulcers	
	Arthritis			Heart Murmur/Mitral Valve Prolapse	
	Asthma			Heart Disease/Heart Attack	
	Anesthesia Reaction			High Blood Pressure	
	Blood Transfusion			High Cholesterol/Lipids	
	Bowel Problems			Kidney Disease/Stones	
	Blood Clots (legs/lungs)			Migraines/Headaches	
	Cancer Type:			Liver Disease	
	Depression/Anxiety			Lung Disease	
	Diabetes			Lupus	
	Diverticulosis			Rheumatic Fever	
	Drug/Alcohol Problem			Seizures/Epilepsy	
	Eating Disorder			Stroke	
	Endometriosis			Thyroid Disease	
	Gallbladder Disease/Stones			Tuberculosis	

List previous hospitalizations/surgeries/serious injuries: *When:*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

*List all medications, supplements and vitamins that you take regularly: **Pharmacy:* _____

Medication	Dosage	Times per day	Reasons for Taking

STATESBORO WOMEN'S HEALTH SPECIALISTS (Medical History Page 2)

Allergies: List any allergies to medications, drugs, chemicals and/or foods: Date/Type of Reaction:

1. _____
2. _____
3. _____
4. _____

FAMILY MEDICAL HISTORY

Include blood relatives: Mother, Father, Sisters, Brothers, Aunts, Uncles, Grandparents (MGM, MGF, PGM, PGF)

**Age = The age when the family member was first diagnosed

ILLNESS	RELATIVE	AGE**	ILLNESS	RELATIVE	AGE**
Birth Defects			Mental Illness		
Blood Clots			Osteoporosis		
Breast Cancer			Ovarian Cancer		
Colon Cancer			Prostrate Cancer		
Depression			Stroke		
Diabetes			Thyroid Disease/ Cancer		
Heart Disease/MI			Uterine Cancer		
High Blood Pressure			Other:		

GYNECOLOGIC HISTORY (Circle Answer)

Have you ever had an abnormal pap smear: NO YES If yes, when:_____What Happened:_____

Infections: Any history of:(circle) Herpes Gonorrhea Chlamydia Genital Warts Trich HPV HIV Syphilis

Age at first period":_____ First Day of Last Menstrual Period: ____/____/____ How long did it last:_____

**If menopausal: What age did it occur:_____ Any bleeding since: YES NO Taking hormones: YES NO

**If having periods: Are they regular: YES NO How often do they occur:_____How long do they last:_____

Period flow: Light Medium Heavy Do you bleed between periods: YES NO Clots: YES NO

Current Method of birth control: (circle answer) Pills Patch IUD Nuva Ring DepoProvera Condoms Essure
Tubes Tied Vasectomy Foams/Sponge Implanon Rhythm Method

SOCIAL HISTORY (Circle Answer)

Marital Status: Single Married Separated Divorced Widowed

Alcohol Use: Never Occasionally Daily Former Age Started: _____Age Stopped: _____ Amount:_____

Tobacco Use: Never Occasionally Daily Former Age Started: _____Age Stopped: _____ Amount:_____

Illicit Drug Use: Never Occasionally Daily Former Age Started: _____Age Stopped: _____ Amount:_____

Education: Highest level or grade completed:_____Occupation:_____

History of Abuse: None Physical Sexual Emotional Details:_____

OBSTETRICAL HISTORY

Total Pregnancies #:_____ Full Term (Born after 37 wks) #:_____ Preterm (Between 20-37 wks) #:_____

Elective Abortions #:_____ Miscarriages (Prior to 20 wks) #:_____

Ectopic/Tubal Pregnancies #:_____ Multiple Pregnancies #:_____Living #:_____

Date	Pregnancy Week	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Complications	Location

GENETIC HISTORY

Do any of the following genetic problems run in your immediate family? NO YES (Circle and list relative)

Thalassemia
Down Syndrome
Canavans Disease
Muscular Dystrophy
Huntington's Chorea

Neural Tube Defect
Tay-Sachs Disease
Sickle Cell Disease
Cystic Fibrosis
Mental Retardation/Autism

Heart Defect
Hemophilia
Fragile X

Other:_____

natera | Empower™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Family History Questionnaire

Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text EMPOWER to 636363.

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

Please complete the following for you and your family members:		Age at diagnosis	Enter family member, cancer type, and age at diagnosis		
		You	Siblings/Children	Mother's side	Father's side
Example:	**Breast cancer** ☒ Y ☐ N	Age 46	Daughter, Breast, 23 Sister, Ovarian, 52	Aunt, Breast, 63 Aunt, Breast, 48	Grandma, Uterine, 81
1. Breast cancer < age 50	☐ Y ☐ N				
2. Either colon cancer or uterine cancer < age 50	☐ Y ☐ N				
3. Triple negative breast cancer ≤ age 60	☐ Y ☐ N				
4. Two or more breast cancers in the same person (first diagnosis ≤ age 50)	☐ Y ☐ N				
5. Two or more colon and/or uterine cancers in the same person	☐ Y ☐ N				
6. Two family members with breast, colon or uterine cancer (one ≤ age 50)	☐ Y ☐ N				
7. Three or more family members from the same side with breast cancer	☐ Y ☐ N				
8. Three or more family members with colon and/or uterine cancer	☐ Y ☐ N				
9. Ovarian cancer Pancreatic cancer Male breast cancer 10 or more precancerous colorectal polyps	☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N				
10. Ashkenazi Jewish **AND** breast cancer or prostate cancer	☐ Y ☐ N				
11. You or a close family member has a known gene mutation. Please list _____	☐ Y ☐ N				
12. Other cancers not listed above (Please complete ALL columns if applicable)	☐ Y ☐ N				
13. Limited or unknown family history	☐ Y ☐ N	Please explain:			
14. Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	If Yes, approximately when:			

Have you ever been diagnosed with breast cancer? ☐Y ☐N If no, complete the following:

1. Height (ft/in) _____ 2. Weight (lbs) _____ 3. Have you had children? ☐Y ☐N How old were you when you had your first child? _____
4. Approximate age at first menstrual period? _____ 5. Have you gone through menopause? ☐Y ☐N ☐Ongoing If yes, at approximately what age? _____
6. Are you of Ashkenazi Jewish descent? ☐Y ☐N ☐I don't know
7. Have you ever used hormone replacement therapy? ☐Y ☐N ☐Ongoing If yes, when? Start date _____ End date _____
   If yes, what type? ☐ Estrogen ☐ Progesterone ☐ Combined ☐ I don't know
8. How many sisters do you have? _____ Daughters? _____ Maternal aunts? _____ Paternal aunts? _____ Maternal half-sisters? _____ Paternal half-sisters? _____
9. Have you ever had a breast biopsy? ☐Y ☐N If yes, what was the result? ☐ Hyperplasia ☐ Atypical hyperplasia ☐ LCIS ☐ I don't know

Signatures

Patient Name _____ Patient Signature _____ Date _____

Provider Name _____ Provider Signature _____ Date _____

For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

Patient offered hereditary cancer genetic testing (check all that apply)

☐ Yes ☐ No ☐ Patient accepted ☐ Patient declined

Patient previously tested ☐ Yes ☐ No