ANDREW H. KRINSKY, MD., LLC New/Update PATIENT FORM

(Please Print Clearly)

PATIENT NAME:_____ **DATE:**_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SS#: _____ **DOB:** _____ **SEX (circle one): M F**

HOME PHONE: _____ **CELL:** _____ **FAX:**_____
(please circle your preferred phone #)

EMAIL ADDRESS:_____

MARITAL STATUS (circle one): S M W D REFERRED BY: _____

EMPLOYER: _____

ADDRESS: _____ **PHONE:** _____

SPOUSE: _____

SPOUSE EMPLOYER: _____

ADDRESS: _____ **PHONE** _____

PRIMARY LANGUAGE SPOKEN:_____ **DO YOU NEED A TRANSLATOR?: YES___ NO___**

IN CASE OF EMERGENCY: _____ **PHONE:**_____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU: _____

PHONE: _____

PHARMACY NAME:_____ **PHONE NUMBER:**_____

LOCATION:_____

IF OVER 18, DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?: YES_____ NO_____

IF NO, WOULD YOU LIKE INFORMATION CONCERNING YOUR RIGHTS REGARDING ADVANCE DIRECTIVES?: YES_____ NO_____

INSURANCE:_YES_____ **NO** _____ **PROVIDE COPY OF CARD**

PRIMARY CARE NAME:_____

ADDRESS:_____ **CITY**_____ **STATE**_____

PHONE:_____ **FAX:**_____

Revised 08-15-16

Notice of Malpractice Insurance, No Show Appointments & Assignment of Benefits

A: I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Andrew H. Krinsky LLC, Inc.

B: **I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said Assignor to release all information necessary to secure payment.**

C: **I understand it is my responsibility to know what my insurance coverage is, if I am responsible for any deductible, co-ins or copay.**

D: **EVEN THOUGH WE MAY HAVE CONTACTED YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE, IT IS NOT A GUARANTEE OF PAYMENT.**

E: Payments **MUST** be made at the time of each visit, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I understand Andrew H. Krinsky LLC, Inc. reserves the right to charge an administrative fee of $15.00 for any deductible, co-ins or copay not paid at the time of service. A surcharge of 35% will be added to any accounts sent to our collection department.

F: We confirm appointments as a courtesy, it is your responsibility to be aware of the date and time.

G: I understand that I will be charged a $25.00 fee for any no show appointments or cancellations without 24 hour prior notice.

H: I understand that as of 03/01/05 Dr Krinsky does not carry medical malpractice insurance.

I. Dr. Krinsky's practice primarily consists of office gynecology and minor outpatient surgery. Should you need hospitalization or major surgery Dr. Krinsky will provide you with an appropriate referral.

J. If you are going to be more the 10 minutes late for your appointment, we ask that you make a courtesy call informing the office. If you are more then 20 minutes late for your appointment depending on how the schedule is running, you may be asked to reschedule your appointment.

K. I understand that it may be necessary for Dr. Krinsky to perform certain lab tests during my visit that may not be covered by my insurance company. In that event I understand I will be responsible for the charge upon check-out.

I HAVE READ AND UNDERSTAND THE ABOVE

Signed by: _____ DATE: _____

I herby authorize my medical information and/or results to be discussed with anyone listed below.

Signed by: _____ DATE: _____

Patient:_____ Date:_____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

General

Have you gained or lost weight recently? Y N
How many pounds? ___
Other

Neurological

Trouble sleeping Y N
Headache Y N
Seizures Y N
Other

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other

Cardiovascular

Chest pain Y N
Varicose veins Y N
High blood pressure Y N
Other

Integumentary

Skin rash Y N
Nipple discharge Y N
Persistent itch Y N

Genitourinary

Urine retention Y N
Painful urination Y N
Frequent urination Y N
Other

Respiratory

Asthma Y N
Frequent cough Y N
Shortness of breath Y N
Other

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Anemia Y N

Psychiatric

Are you unhappy with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other

Physician Reviewed: _____

CURRENT PRESCRIPTIONS

PT NAME	TODAYS DATE

Drug Name	Generic for	Dose	Frequency	Reason Taking

ANDREW H. KRINSKY, M.D., F.A.C.O.G, LLC

GYNECOLOGY

NAME AGE OCCUPATION S.M.D SEP

FAMILY HISTORY	LIVING AGE	LIVING HEALTH	DECEASED AGE	DECEASED HEALTH
FATHER				
MOTHER				
BROTHER OR SISTER 1				
2				
3				
4				
5				
HUSBAND				
SON OR DAUGHTER 1				
2				
3				
4				
5				

Has any relative ever had	NO	YES	WHO
CANCER	☐	☐	
TUBERCULOSIS	☐	☐	
DIABETES	☐	☐	
HEART TROUBLE	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
STROKE	☐	☐	
EPILEPSY	☐	☐	
SUICIDE	☐	☐	
MENTAL ILLNESS	☐	☐	
HYSTEREOTOMY	☐	☐	
CESAREAN SECTION	☐	☐	
KIDNEY TROUBLE	☐	☐	

MENSTRUAL HISTORY

AGE AT ONSET _____
REGULAR ☐ YES ☐ NO
CYCLE_____DAYS (FROM START TO START)
USUAL DURATION _____DAYS
FLOW ☐ LIGHT ☐ MED ☐ HEAVY
PAINS OR CRAMPS ☐ YES ☐ NO
DATE OF LAST PERIOD _____

LIST PREGNANCIES (INCLUDING MISCARRIAGES)

YEAR	WEIGHT	SEX	HRS OF LABOR	ANESTHESIA	COMPLICATIONS

PERSONAL HISTORY

WEIGHT NOW_____ 1 YEAR AGO_____ HIGHEST_____ WHEN_____

HAVE YOU EVER HAD	NO	YES
GERMAN MEASLER	☐	☐
MUMPS	☐	☐
CHICKEN POX	☐	☐
SCARLET FEVER	☐	☐
DIPTHERIA	☐	☐
PNEUMONIA	☐	☐
RHEUMATIC FEVER	☐	☐
HEART DISEASE	☐	☐
HEART MURMUR	☐	☐
POLIO OR MENINGITIS	☐	☐
KIDNEY INFECTIONS	☐	☐
GONORRHEA OR SYPHILIS	☐	☐
ANEMIA	☐	☐
JUANDICE	☐	☐
GALLBLADDER DISEASE	☐	☐
EPILEPSY	☐	☐
MIRRAINE HEADACHES	☐	☐
TUBERCULOSIS	☐	☐
VALLEY FEVER	☐	☐
CANCER	☐	☐
HIGH OR LOW BLOOD PRESSURE	☐	☐
NERVOUS BREAKDOWN	☐	☐

DO YOU NOW HAVE OR HAVE EVER HAD	YES	NO
ANY EYE DISEASE, INJURY, IMPAIRED SIGH	☐	☐
ANY EAR DISEASE, INJURY, IMPAIRED HEAI	☐	☐
ANY TROUBLE WITH NOSE, SINUSES, MOUT	☐	☐
ANY HEAD INJURY, FAINTING SPELLS, CON	☐	☐
FREQUENT OR SEVERE HEADACHES	☐	☐
SKIN DISEASE	☐	☐
CHRONIC OR FREQUENT COUGH	☐	☐
CHEST PAIN, SPITTING UP BLOOD	☐	☐
NIGHT SWEATS	☐	☐
SHORTNESS OF BREATH	☐	☐
SWELLING OF HANDS, FEET, OR ANKLES	☐	☐
VARICOSE VEINS	☐	☐
KIDNEY OR BLADDER DISEASE	☐	☐
INDIGESTION, STOMACH TROUBLE, OR ULC	☐	☐
RECTAL BLEEDING, CONSTIPATION OR DIAI	☐	☐
LOSS OF URINE WITH COUGH OR SNEEZE	☐	☐

ALCOHOLIC BEVERAGE ☐ NEVER ☐ MOD ☐ DAILY
CIGARETTES_____PACKS PER DAY
SURGERY - (IF YES, WHAT, WHEN, WHERE)

ALLERGIES _____
TRANSFUSIONS - (IF YES, NUMBER) _____
WHAT MEDICINES ARE YOU NOW ON:_____

01/17

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____
Reason for Today's Visit: _____

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 COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ 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)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

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

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

Patient's Signature: _____ Date: _____

Healthcare 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: _____

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Telephone: (954) 722-2002 ~ Fax: (954) 722-2041

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.