

Patient Demographic Form

Patient Name: _____ Date of Birth: _____

SS# _____

Policy Holder _____

Address _____

Address _____

Apt. # _____

Apt. # _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Home # _____ Cell # _____

Tel # _____

Language Spoken _____

Relationship _____

Marital Status: S M W D Race: B W H O _____

Referred by: _____

E-mail

Grid for E-mail address input

Primary Care Physician _____

Pharmacy _____

Employer _____

Address _____

Phone _____

Phone _____

In case of emergency, notify:

Phone _____

Nearest friend or relative not living with you:

Phone _____

Medical Insurance:

Primary _____

Medicare # _____

Insured _____ D.O.B. _____

Secondary _____

ID# _____

Insured _____

Group# _____

ID# _____

Group# _____

Assignment of benefits to facilitate the processing of claims

- 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 Lona Sasser, D.O. LLC.
b. I understand that I am financially responsible for all charges whether or not paid by said by said insurance. I hereby authorize said assignor to release all information necessary to secure the payment.
c. Payments MUST be made at the time of each visit, unless prior payment arrangements have been made. A surcharge of 35% will be added to any accounts sent to our collections department.

I have read and understand the above.

Signed: _____

Date: _____

LONA SASSER D.O., LLC

Dr. Lona Sasser D.O. and Dr. Mary-Beatrice Squire MD

FINANCIAL POLICY

Thank you for choosing our practice. We want to make every experience you have with us a positive one. Over the past few years, the practice of medicine has become more complicated for our physicians and patients alike, due to managed care rules and regulations. Because of the growing complexity of the insurance business, we would like to help clarify the relationship between the insurance company, the doctor, and the patient. In an effort to better assist you, we have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the insurance office staff. You will be asked to sign at the end of this form.

UNINSURED PATIENTS If you do not have current health insurance coverage, our policy is to collect payment at the time of service.

CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCE A copayment is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and co-insurance. You will be asked to pay your co-payment, deductible, and co-insurance amount at the time of service if your deductible has not been met. We will verify if your deductible has been met with your insurance company prior to your visit. Co-insurance is the amount required by some insurance plans over and above the deductible amount. Our office verifies each patient's financial responsibility with their insurance company but can not guarantee final financial responsibility until claims have been submitted and finalized by the insurance company.

LABORATORY AND HOSPITAL FEES Many times it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood work, culture, etc) is done in our office, the actual test is usually carried out by someone else. This means that you will receive a separate bill from the lab. If you have a question about a bill you receive from a lab, hospital, or outpatient center, please contact them directly to resolve any billing concerns. Please note that *if you have a deductible the hospital or surgical center will require payment of this before the procedure*. Our office is separate from these facilities and we ask that you please contact the hospital or surgical center directly with any billing issues or questions.

OBSTETRICAL PATIENTS- Individual payment plans will be set up for each patient based upon your insurance coverage. Our office policy is to collect all payments by the beginning of the 7th month of pregnancy.

FORMS OF PAYMENT For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover, and American Express. We also offer our patients the option of applying for CareCredit if needed.

RETURNED CHECKS All returned checks will result in a \$40 NSF fee which will be applied to your account.

ESTIMATION OF SERVICES We will be happy to give you an estimate of fees when this is possible. Please remember that we can only assure you of the exact cost of a procedure on the day of service when the doctor has determined the actual code being used. The estimate of our charges will not include work done by an outside lab or pathology service.

COLLECTION EFFORTS We will make every effort to work with you to make payment arrangements should your bill become outstanding. If all efforts do not bring about a resolution of the account after several attempts, the account balance will be turned over to collections.

I have read and understand the above completely and agree to comply with the financial policies of this office. My signature authorizes this office to file my claims and assigns to this office all rights, title, and interest to my medical reimbursement benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my visits to my insurance carrier. I understand that I am responsible for my bills in the event the insurance company denies any claims.

Signature of patient (or parent, if patient is a minor)

Date

Lona Sasser, D.O.

Mary-Beatrice Squire, M.D.

Lona Sasser, D.O. LLC

Patients' rights of disclosures: In general, HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of the health information be made by alternative means.

I, _____, wish to be contacted in the following manner:

Home:

- Ok to leave a detailed message
- Leave a message with callback number only

Cell Phone:

- Ok to leave a detailed message
- Leave a message with callback number only

Work:

- Ok to leave a detailed message
- Leave a message with callback number only

Written communication:

- Ok to mail to home
- Ok to fax to home fax # _____
- Ok to fax to work fax # _____

List all persons in your household who, in your absence, may make requests on your behalf; and with whom we may speak to regarding your medical information.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Date: _____

PLEASE FILL OUT THE BACK OF THE FORM →

Lona Sasser, D.O.

Lona Sasser, D.O. LLC Mary-Beatrice Squire, M.D.

3111 N. University Drive, Suite 308
Coral Springs, FL 33065
(954) 340-1050

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have the right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand my request that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations must be in writing. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement to this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Notice of Privacy Practices

Lona Sasser, Do, LLC

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.

HOW WE MAY USE AND DISCLOSE HEALTH

INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:

We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.

We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care.

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying
"Acknowledgement" form

Melissa Fisher
3111 N University Drive Suite 308
Coral Springs, Florida 33065
Oficina: (954) 340-1050
Fax: (954) 340-5275

Name _____

Reason for Visit

What brings you to the office today?

How is your general health?

Excellent Good Fair Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following?

Adhesive Tape Antibiotics Latex
 Barbiturates (Sleeping Pills) Aspirin Iodine
 Codeine Sulfa Local Anesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

Past Medical History

- | | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | |

Hospitalizations & Surgeries

Reason _____	Date _____
Reason _____	Date _____

Lifestyle Factors

Are you sexually active?

Yes No # of partners in past year _____

Do you wish to be checked for STDs?

Yes No

Has anyone in your home ever physically or verbally hurt you?

Yes No

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs?

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Family History

Has anyone in your family ever had any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |

Details:

Is your mother alive? Yes ___ Current Age ___

No ___ Age at death ___

Is your father alive? Yes ___ Current Age ___

No ___ Age at death ___

OBGYN History

Have you ever had or do you currently have any of the following?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abnormal Vaginal Bleeding | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Bleeding between Periods | <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> DES Exposure | <input type="checkbox"/> HPV | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Extreme Menstrual Pain | <input type="checkbox"/> Infertility | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Irregular Periods/Bleeding | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Nipple Discharge | <input type="checkbox"/> Yeast Infections – Frequent |

Pregnancy History

Please describe any pregnancies you have had.

_____ # of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Were there any complications associated with any of your pregnancies?

Are you currently pregnant?

- Yes No

Are you trying to become pregnant?

- Yes No

Do you need birth control or contraceptive advice?

- Yes No

What method of birth control do you use?

Menstrual History

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular?

- Yes No

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
<input type="checkbox"/> Blood Sugar-Fasting	_____	_____
<input type="checkbox"/> Breast Self Exam	_____	_____
<input type="checkbox"/> Cholesterol Test	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> CT/CAT Scan	_____	_____
<input type="checkbox"/> Dexascan (Bone Density)	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Fecal Occult Blood Test	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Pap Smear	_____	_____
<input type="checkbox"/> Physical Exam	_____	_____
<input type="checkbox"/> Cardiac Stress Test	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Gender (M/F): _____ Today's Date(MM/DD/YY): _____ Health Care Provider: _____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.

If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
Have you or your family members been diagnosed with any of the following:		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	<input checked="" type="radio"/> Y <input type="radio"/> N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	<input type="radio"/> Y <input type="radio"/> N				
2 or more separate breast cancers in one person, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
2 or more people on the same side of my family (can include me) with breast cancer , one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
Ovarian (peritoneal/fallopian tube) cancer at any age	<input type="radio"/> Y <input type="radio"/> N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	<input type="radio"/> Y <input type="radio"/> N				
3 or more of these cancers on same side of my family at any age: pancreatic, breast, or aggressive prostate* <small>*Gleason Score ≥7</small>	<input type="radio"/> Y <input type="radio"/> N				
Male breast cancer at any age	<input type="radio"/> Y <input type="radio"/> N				
Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age	<input type="radio"/> Y <input type="radio"/> N				
Pancreatic cancer or aggressive prostate cancer and one relative with breast cancer at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
20 or more colon/rectal polyps found in 1 person throughout their lifetime. Specify number _____	<input type="radio"/> Y <input type="radio"/> N				
Colon/rectal or Endometrial (uterine) cancer before age 50	<input type="radio"/> Y <input type="radio"/> N				
Personal history of Endometrial (uterine) cancer at any age [†]	<input type="radio"/> Y <input type="radio"/> N				
TWO individuals on the same side of my family (can include me): at least 1 with colon/rectal or endometrial (uterine) cancer at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	<input type="radio"/> Y <input type="radio"/> N				
THREE OR MORE individuals on the same side of my family (can include me) with a Lynch-associated* cancer at any age, with at least 1 being a colon/rectal or endometrial (uterine) cancer	<input type="radio"/> Y <input type="radio"/> N				

[†] PREMM_(1,2,6) Score ≥ 5%

* Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

Have you or a family member had genetic testing for a **hereditary cancer syndrome**?

Y N

If yes, Who? _____ What gene(s)? _____
 What was the result? _____

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

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

If YES, which test? BRACAnalysis® with Myriad myRisk® Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk

COLARIS®PLUS with Myriad myRisk COLARIS AP®PLUS with Myriad myRisk Single Site Testing Myriad myRisk Update Other: _____

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