Hereditary Cancer Risk Assessment Form

PATIENT INFORMATION: (Please print)

Last Name: _____ First Name: _____ M.I. _____ Date: _____

DOB: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Height: _____ Weight: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Preferred method of contact: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ E-mail

E-mail Address: _____

Patient Address (street): _____ City: _____

State: _____ Zip Code: _____

Sex (assigned at birth): ☐ Male ☐ Female Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

☐ Unspecified ☐ Other (please describe) _____

Gender Identity: ☐ Male ☐ Female ☐ Nonbinary ☐ Self-Described

Sexual Orientation: ☐ Straight/Heterosexual ☐ Gay/Lesbian ☐ Bisexual

Race/Ethnicity: ☐ Ashkenazi Jewish ☐ Asian ☐ Black ☐ French Canadian ☐ Hispanic ☐ Mediterranean

☐ Native American ☐ Pacific Islander ☐ Sephardic Jewish ☐ White ☐ Other (please describe) _____

Preferred language for medical appointments? _____

Are you visually impaired? ☐ Yes ☐ No Are you hard of hearing? ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____

Emergency/Phone: _____ Emergency/Alternate Phone: _____

REFERRAL INFORMATION: (Please print)

Self-Referred: ☐ Yes ☐ No

Referring Doctor First Name: _____ Last Name: _____

Practice Name: _____ Phone Number: _____

Reason for Referral:

_____

_____

_____

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FAMILY HISTORY: (Please print)

Please list any close relatives (siblings, parents, aunts/uncles, first cousins) who have had cancer:

Relative		Type of cancer	Age at diagnosis		Did they have genetic testing?	Did they test positive?
	☐ Maternal ☐ Paternal			☐ Alive ☐ Deceased	☐ Y ☐ N ☐ Unknown	☐ Y ☐ N
	☐ Maternal ☐ Paternal			☐ Alive ☐ Deceased	☐ Y ☐ N ☐ Unknown	☐ Y ☐ N
	☐ Maternal ☐ Paternal			☐ Alive ☐ Deceased	☐ Y ☐ N ☐ Unknown	☐ Y ☐ N
	☐ Maternal ☐ Paternal			☐ Alive ☐ Deceased	☐ Y ☐ N ☐ Unknown	☐ Y ☐ N

If you can get a copy of your family member's genetic testing report, please send to:
Daniel.Mesenhowski@usoncology.com

SOCIAL HISTORY: (Please print)

Do you drink alcoholic beverages? ☐ Y ☐ N How many drinks per week/month? ____________________

Have you ever smoked cigarettes? ☐ Y ☐ N Are you currently smoking? ☐ Y ☐ N

Packs per day? ____________ How many years? ______________ When did you quit?______________

Do you use recreational drugs? ☐ Y ☐ N How often? _______________ How much? __________________

What type? _________ If quit, when?_______________

With whom do you live/support system? ________________ Your occupation? ________________________

Are you currently retired? ☐ Y ☐ N

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MEDICAL INFORMATION: (Please print)

Have you ever been diagnosed with cancer (including DCIS or LCIS)? ☐ Y ☐ N

If yes, please fill out chart below:

Age at diagnosis?	List treatment	Did the cancer spread to other parts of the body?	Was there a recurrence?

Do you see the doctor for any other medical diagnoses? ☐ Y ☐ N

Please list the other doctors you see and why you see them: _____

_____

_____

Please list the surgeries you've had: _____

_____

_____

GYNECOLOGIC HISTORY: (For those assigned female at birth)

Age at first period: _____ Do you still get your period? ☐ Y ☐ N

How old were you when you stopped getting your period? _____

How many times have you been pregnant (including miscarriages and abortions): _____

How old were you when your first child was born? _____ Have you been told you have dense breasts? ☐ Y ☐ N

Have you ever been on Hormone Replacement Therapy (HRT)? ☐ Y ☐ N

Total number # of years and type (estrogen versus combined): _____

Have you ever used birth control pills? ☐ Y ☐ N

Total number # of years and type: _____

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PREVENTATIVE HEALTH MAINTENANCE:

Have you had any of the following?		If so, when was this last done (list the year)?	List the doctor's office/practice where this was done.	
Colonoscopy	☐ Y ☐ N			Total number of polyps in your lifetime?_____
Upper endoscopy	☐ Y ☐ N			
Mammogram	☐ Y ☐ N ☐ Not Applicable			
Breast MRI	☐ Y ☐ N ☐ Not Applicable			
Breast biopsy	☐ Y ☐ N ☐ Not Applicable			What were the results? _____ _____
Dermatology	☐ Y ☐ N			
Prostate exam	☐ Y ☐ N ☐ Not Applicable			
Pap smear	☐ Y ☐ N ☐ Not Applicable			

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Patient Name: _____ _____
Last First M.I. Today's Date

( ) _____ ( ) _____
Home Telephone Cell phone

Home Address: _____ Mailing Address: _____

_____ _____
City State Zip City State Zip

DOB: _____ Age _____ ☐ M ☐ F SS# _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Sex

Employer: _____ ( ) _____
Name Telephone

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Virginia Cancer Specialists, P.C. I also authorize agents of any hospital, treatment center or previous physician to furnish Virginia Cancer Specialists, P.C. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Virginia Cancer Specialists, P.C.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Virginia Cancer Specialists, P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Virginia Cancer Specialists, P.C.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (circle one)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (circle one)

PHYSICIAN _____
ACCT NBR _____ LOC _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Virginia Cancer Specialists, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Virginia Cancer Specialists.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Virginia Cancer Specialists Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained and employee signature:

_____

_____

_____

Virginia Cancer Specialists

PERMISSION FOR VERBAL COMMUNICATIONS

To protect the patient's privacy and to ensure that our clinic staff and physicians know whom they have permission to communicate with regarding the patient's protected health information, it is helpful for patients to have a Permission for Verbal Communications form on file at Virginia Cancer Specialists.

_____

Patient's Name

I permit Virginia Cancer Specialists to discuss health information with the following individuals involved in my medical care or payment of my care:

List individuals and state the person's relationship to the patient.

Name	Phone Number	Relationship
1.		
2.		
3.		

****

This authorization is limited to discussions regarding the following medical condition(s):

_____

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

****

This authorization is limited to the following timeframe from

_____ (date) to _____ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

_____

Patient's Signature **Date**

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____

Name of Personal Representative **Relationship to Patient**

_____

Witness **Date**