

PATIENT INFORMATION

SOCIAL SECURITY #		HOME ADDRESS		
FIRST NAME	MIDDLE			
LAST NAME		CITY	STATE	ZIP
SEX	DATE OF BIRTH	EMAIL		
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED (CHECK ONE) <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> OTHER		HOME PHONE		
		WORK PHONE		
		REFERRING PHYSICIAN		
		HOW DID YOU HEAR OF US?		

EMPLOYER

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST				
<input type="checkbox"/> COMMERCIAL <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER				
INSURANCE COMPANY				
INSURED / CARD HOLDER'S NAME			RELATIONSHIP	
POLICY #	GROUP#		PHONE	

SECONDARY INSURANCE INFORMATION

<input type="checkbox"/> COMMERCIAL <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER				
INSURANCE COMPANY				
INSURED / CARD HOLDER'S NAME			RELATIONSHIP	
POLICY #	GROUP#		PHONE	

WORKER'S COMPENSATION INFORMATION

COMPANY NAME	COMPANY PHONE
SUPERVISOR'S NAME	SUPERVISOR'S PHONE

EMERGENCY CONTACT

SOCIAL SECURITY #	SEX	
FIRST NAME	MIDDLE	HOME PHONE
LAST NAME		WORK PHONE

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY #	SEX	DATE OF BIRTH
RELATIONSHIP		DAYTIME PHONE
FIRST NAME	MIDDLE	EMPLOYER
LAST NAME		ADDRESS
ADDRESS		CITY STATE ZIP
CITY	STATE	ZIP

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.	SIGNATURE (Patient or Parent if Minor) Date
---	--

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.	SIGNATURE (Patient or Parent if Minor) Date
---	--

Jonathan Buten, MD, PA

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

____ Accepted _____ Denied

Signature **X** _____

Date: _____

Signature of Patient or Legal Representative Witness _____

Date Notice Effective Date or Version _____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
<i>For example:</i> Colorectal cancer		<i>Brother 36 yrs</i>	<i>Aunt 44 yrs Cousin 58 yrs</i>	<i>Grandfather 65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more colon polyps				

MELANOMA

Melanoma				
Pancreatic cancer				

OTHER CANCER

-------	--	--	--	--

FOR OFFICE USE ONLY

<input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <ul style="list-style-type: none"> <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma 	<input type="checkbox"/> Patient given information to review <input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED <input type="checkbox"/> Follow up appointment scheduled Date: _____
--	--

ESTABLISHED PATIENT HISTORY FORM
Jonathan Buten MD, FACOG [Center for Minimally Invasive Gynecology]

NAME _____ Date _____ Age _____ Marital Status _____
Occupation _____ Partner's Name _____ Referred by _____
Reason for Visit _____

Pregnancy History

Please list number of: Times Pregnant _____
Premature Births _____ Miscarriages _____
Abortions _____ Living Children _____

*Physician
Use Only*

Gynecological History

Menstruation:

First day of last Period: _____
Are your periods regular? _____ Length of cycle [28 days, etc.] _____
Degree of flow?: Light _____ Moderate _____ Heavy _____
Do you have pain with your periods? _____
Do you take medication for this? Yes _____ No _____

Pap Smear:

Date of last Pap Smear? _____ Results? _____
Have you ever had an abnormal Pap Smear? Yes _____ No _____

Contraception:

What do you currently use? _____
Problems? _____
Do you wish to continue with this method? Yes _____ No _____

Gynecological Infections:

Do you have discharge at present? Yes _____ No _____
Describe: _____
Please check any that you have had:
Herpes _____ Syphilis _____ Gonorrhea _____ Chlamydia _____
Genital Warts (HPV) _____ PID _____ Trichomonas _____
Do you want to be tested for STDs?
(Sexually Transmitted Diseases?) Yes _____ No _____

Menopause:

If menopausal:
Do you have hot flashes or other symptoms? Yes _____ No _____
Do you use any medication for it? Yes _____ No _____
Do you have any problems with HRT? Yes _____ No _____

Other Gynecological History? (Include any history of ovarian cysts, pelvic pain, endometriosis, fibroids, cervical conization or pelvic surgery, pain with intercourse)

Have you ever been physically or sexually abused? Yes_____ No_____

If yes, do you wish to talk about this? Yes_____ No_____

Do you have any urinary incontinence? Yes_____ No_____

Do you have fecal incontinence or difficulty having a bowel movement?

Yes_____ No_____

Medical History:

Describe any new medical problems with yourself: _____

Describe any new medical problems with your family: _____

Hospitalizations: Please list those operations or serious illnesses that you have had which required hospitalization since your last visit:

Date	Illness or Operation	Complications
		No <input type="checkbox"/> Yes <input type="checkbox"/>
		No <input type="checkbox"/> Yes <input type="checkbox"/>

List any allergies to medications or drugs:

Medications presently taking: _____

Illicit Drug use: Yes_____ No_____ Substance/Amount: _____

Smoking: Yes_____ No_____ Amount: _____

Alcohol: Yes_____ No_____ Amount: _____

Health Maintenance:

Do you exercise regularly? Yes_____ No_____ Sometimes_____

When was your last cholesterol screening? _____

Was it normal_____ Abnormal_____

How many 8 oz servings of yogurt or milk do you average a day? _____

Do you take calcium supplements? Yes_____ No_____

Have you undergone colonoscopy Yes_____ No_____

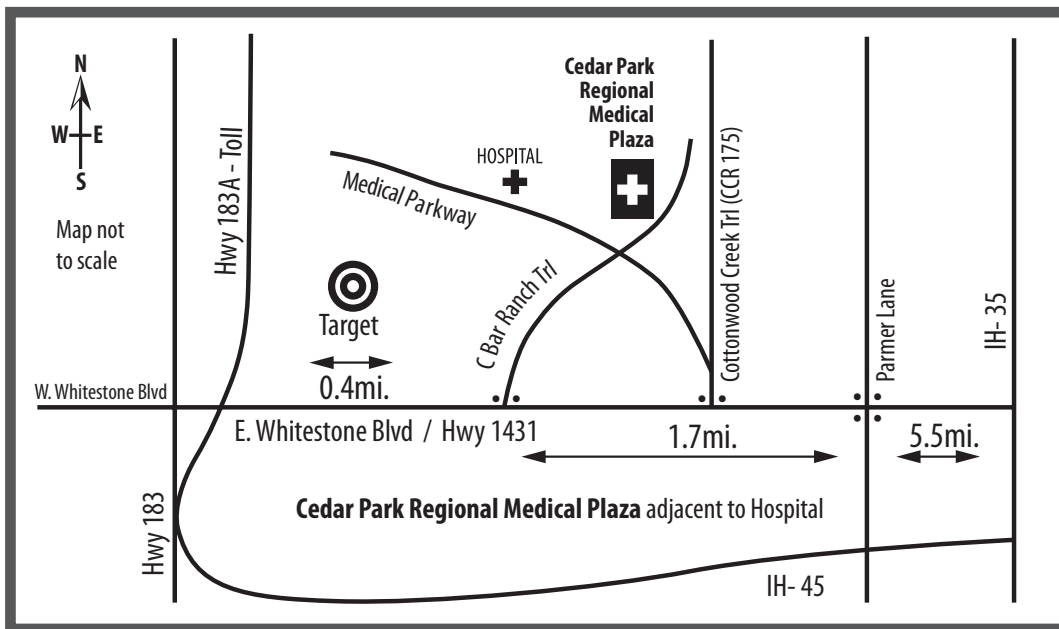
Do you perform SBE (Self Breast Exam)

Monthly_____ Sometimes_____ Never_____

Have you had a mammogram? Yes_____ No_____

Date of last mammogram: _____ Normal?_____ Abnormal?_____

If Abnormal, describe: _____



Directions from 183A

Turn right onto 1431. Left at first light - C Bar Ranch Trail (approx. 0.4 miles from 183A). Cross Medical Parkway and follow sign to Cedar Park Regional Medical Plaza (in front of you).
Park either in front or in rear of building.

Directions from IH35

Go West from IH35 onto 1431. Turn right at C Bar Ranch Trail (approx. 7.2 miles from IH35). Cross Medical Parkway and follow sign to Cedar Park Regional Medical Plaza (in front of you).
Park either in front or in rear of building.

Directions from Parmer Lane

Turn left onto 1431 then right at C Bar Ranch Trail (approx. 1.7 miles from Parmer Lane). Cross Medical Parkway and follow sign to Cedar Park Regional Medical Plaza (in front of you).
Park either in front or in rear of building.