

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
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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
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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

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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: _____ |
|--|--|

NEW PATIENT HISTORY AND PHYSICAL FORM

Jonathan B. Buten MD

Date: _____

NAME _____ Marital Status _____ Age _____ DOB _____

Occupation _____ Partner's Name _____

Referred by _____

Reason for Visit _____

Gynecological History

Menstrual History

Age at first menstruation _____ First day of last period _____ Was it normal? _____

Are your periods regular? _____ Length of cycle [first day one to first day of next] _____

Flow?: Light _____ Moderate _____ Heavy _____ Do you have blood clots? _____

Menstrual Pain: Mild _____ Moderate _____ Severe _____ Do you miss work due to your periods? _____ If yes, explain _____

Do you use pain medication for this? _____

If yes, what medication do you use? _____

Do you have any bleeding between your periods? _____

Do you consider your menses to be a problem? _____ If yes, why? _____

*Physician
Use Only*

Contraception

What are you currently using to prevent pregnancy? _____

For how long? _____ Any problems? _____

Do you wish to continue with this or consider another form of contraception?

Yes/No _____ Other? _____

Have you had a tubal ligation? _____

Has your partner had a vasectomy? _____

Past Gynecological History

Include, but not limited to: Gynecological Surgery, Ovarian Cysts, Endometriosis or Fibroids

Current Gynecological Status

Urinary leakage? _____ Frequent Urinary Tract Infections? _____ Urinary urgency? _____

Difficulty emptying your bladder? _____ Vaginal Pressure or Protrusion? _____

Painful Sexual intercourse? _____ Lower Abdominal Pressure? _____

Vaginal Discharge: Color? _____ Odor? _____ Itch? _____

Have you had any treatment? _____

DATE: _____ PATIENT NAME: _____ Date of Birth: _____

Pap Smear

Date of last Pap Smear? _____ Was it normal? _____
Any history of abnormal Pap Smear? _____ If so, describe _____

*Physician
Use Only*

Sexually Transmitted Diseases

Do you or your partner have a history of any of the following – Gonorrhea, Chlamydia, Syphilis, Genital Herpes, HPV or HIV? If so, please give details below:

If you are under the age of 26, have you received the vaccine to prevent HPV (the virus that causes cervical cancer)? _____

If not, would you like to receive it? _____

Menopause

If yes, when? _____ Was this confirmed with blood work? _____

Where _____

Do you suffer from : Hot flashes / Night sweats? _____ Vaginal dryness? _____

Are you on hormonal supplementation? _____ Do you wish to discuss this? _____

Do you feel you are perimenopausal? _____ If so, why? _____

Obstetrical History

Number of pregnancies _____ Premature Births _____ Miscarriages _____

Abortions _____ Living Children _____

Month/yr.	Sex M/F	Type of Delivery Vaginal/C Section Vaginal/Forceps	Complications [yes/no]
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1 _____

2 _____

3 _____

4 _____

5 _____

Previous surgery or other illness that required hospitalization

Date _____ Operation or Illness _____

DATE: _____ PATIENT NAME: _____ Date of Birth: _____

Current Medications

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Physician
Use Only*

Do you take any over the counter medicine, herbal supplements, or other medications?

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES _____

Past General Medical History

	You	Family
Diabetes Mellitus	_____	_____
Thyroid or other Glandular [Endocrine] Disorders	_____	_____
High Blood Pressure	_____	_____
Heart Disease including Rheumatic Fever	_____	_____
Lung Disease [including Asthma and Tuberculosis]	_____	_____
	[Or live with someone with TB]	
Stomach, Bowel or Gall Bladder problems	_____	_____
Hepatitis or other Liver Disorders	_____	_____
	[Or live with someone with hepatitis]	
Kidney or Bladder problems	_____	_____
Blood Clots either in the Legs or Lungs	_____	_____
Anemia or other Blood Disorders	_____	_____
Blood Transfusion	_____	_____
Diseases of the Nervous System	_____	_____
	[Including: Epilepsy or Seizures of any kind]	
Depression or other Psychiatric disorders	_____	_____
Cancer	_____	_____

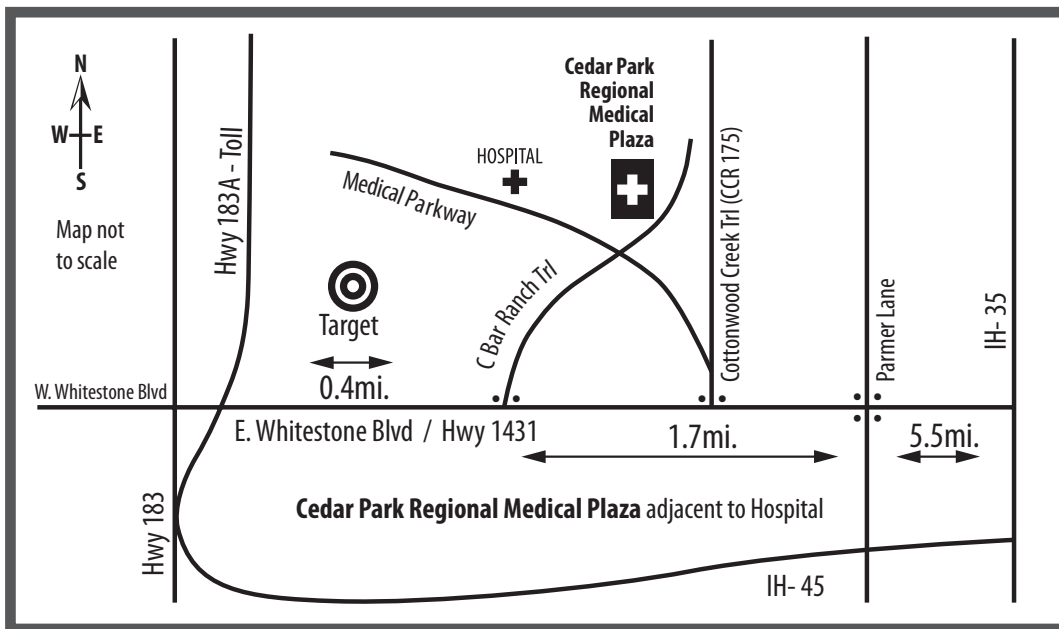
DATE: _____ PATIENT NAME: _____ Date of Birth: _____

Last Mammogram: Date _____ Normal _____ Abnormal _____
Ever Abnormal? _____
Last Routine Lab work: Date _____ Normal _____ Abnormal _____
Where _____
Last Bone Density: Date _____ Normal _____ Abnormal _____
Treatment _____
Have you ever had a Colonoscopy? _____ When? _____
Do you exercise regularly? No _____ Yes _____
How often? _____
Do you perform Self Breast Examinations? No _____ Yes _____
If yes, how often? _____
Have you ever been subjected to either Physical or Sexual Abuse and do you
want us to know about this? _____ or, discuss this with us? _____

*Physician
Use Only*

Any other medical history you wish to share with us?

	You	Family
Drug Abuse	Current _____	_____
	Past _____	_____
Smoking:	Current [how much] _____	_____
	Past _____	_____
Alcohol:	Social _____	_____
	Excessive _____	_____
	Current [how much] _____	_____



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.