METRO OBSTETRICS & GYNECOLOGY

8391 Commerce Road, Suite 101 ✦ Commerce, MI. 48382 ✦ 248-360-9090 ✦ Fax 248-360-9093

PLEASE PRINT CLEARLY & COMPLETE ALL FIELDS

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Last 4 of Social Security: XXX-XX- _____ Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Non-Latino [ ] Other

Race: [ ] Black/African American [ ] American Indian/Alaskan Native [ ] Asian [ ] Hispanic [ ] Native American
[ ] Native Hawaiian [ ] Other Pacific Islander [ ] White [ ] Other [ ] Declined to State

SPOUSE INFORMATION, IF APPLICABLE

Name: _____ Date of Birth: _____ Phone: _____

Employer: _____ Work Phone: _____

Please provide us with your email address ONLY if you would like to sign up for:
IQ Health - our secures online test result system

Email Address: _____

MEDICAL INSURANCE

Primary Insurance Company: _____ Subscriber's name (or "self"), _____ Birth Date: _____

Subscriber's Relationship to Patient: _____ ID#: _____ Group #: _____

Secondary Insurance Company: _____ Subscriber's name (or "self"), _____ Birth Date: _____

Subscriber's Relationship to Patient: _____ ID#: _____ Group #: _____

EMERGENCY CONTACT

Who would you like us to contact in case of emergency? _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC., THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee of $2.50 will be charged on all balances of 31 days and older. In the event of default, I agree to pay a collection cost calculated at 40% of my account balance and any reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date: _____ Your Signature: _____

Thank you for your careful completion of this form.

Risk Assessment for Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to <u>YOU and/or YOUR FAMILY</u> (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins
Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer* (ER-, PR-, HER2-pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		POLYPOSIS SYNDROMES	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			

		MELANOMA	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Two or more melanomas in an individual or family			
Y	N	Melanoma and pancreatic cancer in an individual or family			

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain: _____

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing:
☐ HBOC ☐ Lynch ☐ Polyposis ☐ Melanoma

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing: ☐ Accepted ☐ Declined

_____ _____
Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

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