



The Center for Gynecologic Oncology

Jacob Tangir M.D.
Gynecologic Oncology and Pelvic Surgery
www.centergynonc.com

CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosure) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notice of the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

Signature: _____ Date: ____/____/____

If signed by a patient representative, state relationship to patient _____



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INSURANCE FORM

Note: You need to make a choice about receiving these health care items of services.

Patient's name: _____

Date: ___/___/_____ Insurance Plan: _____

The fact that your insurance carrier may not cover a service does not mean that you should not receive the service. There is a medical reason for why your physician recommended said service(s). The purpose of this form is to help you make an informed choice about whether or not, to receive said service(s) understanding that you may have to pay for this yourself. Please read this information in its entirety prior to signing.

- You are encouraged to contact your insurance plan directly prior to services being rendered if you have any questions regarding service(s) rendered.

It is the patient's responsibility to obtain verification of their insurance plan benefits. **Verbal or On-line verifications** in **NOT** a guarantee of payment. Services are subject to the limitations and exclusions including pre-existing conditions as stated in the insurance benefit plan.

I understand that in the event my insurance determines a service does not meet their definition of medical necessity or is considered a non-covered service due to plan exclusions and limitations including pre-existing conditions, I will be financially responsible for payment of the service(s).

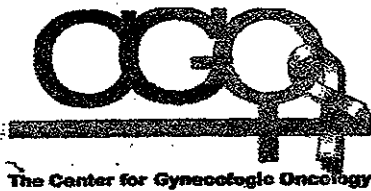
Diagnostic imaging services scheduled by our office at an outside facility

Our office makes every attempt to schedule **ALL** diagnostic testing/surgical procedures at a facility that is participating with your insurance plan. However, due to the constant addition and termination of plan affiliations it is the patient's responsibility to confirm participation prior to receiving services.

I acknowledge that the office has provided me with a copy of this disclosure and understand the contents.

Patient /Insured Signature: _____ Date: ___/___/_____

If signed by a patient representative, state relationship to patient _____



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NAME: _____ BIRTH DATE: / / DATE: / /
 CELL TEL: () _____ WORK TEL: () _____
 REFERRING PHYSICIAN _____ TEL #: _____
 ADDRESS REFERRING DR: _____

AGE _____
 REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IF PRESENT OR NOT			NOTES
	No	Yes	
1. CONSTITUTIONAL			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
3. ENT/MOUTH			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IF PRESENT OR NOT

	NO	YES	NOTES
9. SKIN/BREAST			
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGICAL			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
11. PSYCHIATRIC			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO	Cancer	YES	NO
Asthma			Ulcers		
Pneumonia			Depression/anxiety		
Chronic Lung Disease			Anemia/Blood transfusions		
Kidney Infections/stones			Seizures/convulsions/epilepsy		
Tuberculosis			Bowel trouble		
Venereal Disease			Glaucoma		
Heart Trouble/murmur			Arthritis/joint pain		
Diabetes			Fracture		
High Blood Pressure			Hepatitis/yellow jaundice		
Stroke			Thyroid Disease		
Rheumatic Fever					
HOSPITALIZATIONS <input type="checkbox"/> No <input type="checkbox"/> Yes					
Reason	Date	Reason	Date		
OPERATIONS <input type="checkbox"/> No <input type="checkbox"/> Yes					
Type	Date	Type	Date		
LAST IMMUNIZATION OR TEST <input type="checkbox"/> No <input type="checkbox"/> Yes					
Tetanus	Date	Pneumonia	Date		
Flu Shot		TB Skin Test			

OB/GYN HISTORY			
Births		Abortions	
Miscarriages		Living children	
Age first menstruation		Last menstruation	
CURRENT MEDICATIONS			
Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY						
Illness	Yes	Relative	Illness	Yes	Relative	Age
Diabetes			Breast Cancer			
Stroke			Colon Cancer			
Heart Disease			Ovarian Cancer			
High Blood Pressure			Uterine Cancer			

SOCIAL HISTORY						
Habits						
Smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Packs per day	_____	Years	_____
Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drinks per day	_____	Drinks per week	_____
Drug Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Seat Belt Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Regular Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Personal Profile						
Marital Status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced	<input type="checkbox"/>	
Number of Living Children	_____					
Number of people in household	_____					
School Completed	High School <input type="checkbox"/>	College <input type="checkbox"/>	Graduate Degree	<input type="checkbox"/>	Other	<input type="checkbox"/>
Current or most recent job	_____					

PREVENTIVE STUDIES		
Test	Date Last	Results
Pap Smear		
Colonoscopy		
Mammogram		
Bone Density		

Completed by: Patient Office Nurse Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review of History

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____