

AFA OB/GYN Medical History Form

Name: _____
Date of Birth: _____
Today's Date: _____

Latex Allergy: Yes or No (please circle)

Medications and Dose (including supplements and herbs):

Allergies to Medications: _____

History: Please check and explain only the items that apply to you.

- Genetic Disease _____
- Heart Disease/Murmur _____
- High Blood Pressure/Stroke _____
- Seizures/Epilepsy _____
- Migraines _____
- Depression, Anxiety, or Psychiatric Illness _____
- Lung Disease/Asthma/TB _____
- Phlebitis/Pulmonary Embolism _____
- Kidney Disease _____
- Thyroid Disease _____
- Hepatitis/Liver Disease _____
- Diabetes _____
- Anorexia/Bulimia _____
- Cancer _____
- Other Major Illnesses/Medical Problems _____

Family History: Please specify anyone in your family and indicate their relation and age at diagnosis

Breast Cancer _____ Uterine Cancer _____
 Ovarian Cancer _____ Colon Cancer _____
 Diabetes _____

Surgical History: Please list any surgeries you have had and when.

Have you or any of your family members ever had any difficulties with anesthesia? _____

Social History: (please circle)

Do you smoke? Yes or No (# cigs/day) _____
 Do you use alcoholic beverages? Yes or No (how many per week) _____
 Do you use or have you used street drugs? Yes or No (which ones) _____

Gynecological History: Please explain the following.

Have you ever had an abnormal papsmear? _____
 When did you get your first period? _____ How far apart are your periods? _____ How many days do you flow? _____
 Flow: Light Moderate Heavy
 Are you post-menopausal? _____ since when? _____
 Have you ever used hormone replacement? _____
 Do you get recurrent vaginal infections? _____
 Have you ever been a victim of abuse? (sexual, physical or emotional) _____ Do you feel safe in your current relationship? _____
 Have you had DES exposure? _____
 Present Contraception _____

Date of last papsmear: _____ Date of last mammogram: _____
 Date of last colonoscopy: _____ Date of last bone density: _____

Previous Pregnancies:

No:	Year	Miscarriage	Vaginal	C/Section	Labor (# of hrs)	Sex of Baby	Birth Weight
1							
2							
3							
4							

Any other pregnancy history? _____

Initials: _____

Family History Screening

Patient Name: _____ Date of Birth _____ Date Completed _____

Family history is very important to your physician for proper health management. Please fill out to the best of your ability.
PLEASE USE THE FOLLOWING FAMILY MEMBERS FOR QUESTIONS BELOW

- Self/Siblings
- Half Siblings
- Mother/Father
- Children
- Cousins
- Grandparents
- Aunts/Uncles
- Nieces/Nephews
- Grandchildren
- Great Grandparents

Circle Y for those that apply with description (self/sibling, your mother's and your father's side)

Y	N	Have you ever been tested for inherited risk of cancer -genetic testing for BRCA, Lynch Syndrome? Year Tested? Test name/Result?	SELF or Sibling	Relative Mother's Side	Relative Father's Side	AGE AT DIAGNOSIS
<input checked="" type="radio"/>	<input type="radio"/>	EXAMPLE: Ovarian cancer - at ANY age?			<i>Grandmother</i>	<i>50y</i>
<input type="radio"/>	<input type="radio"/>	1. Ovarian Cancer – <u>at ANY age?</u>				
<input type="radio"/>	<input type="radio"/>	2. Male breast cancer <u>at ANY age?</u>				
<input type="radio"/>	<input type="radio"/>	3. Breast Cancer at 49 years or younger?				
<input type="radio"/>	<input type="radio"/>	4. Breast cancer twice in the same person				
<input type="radio"/>	<input type="radio"/>	5. Three or more of the following cancers on the same side of your family: breast, prostate, pancreatic, ovarian <i>(specify cancer w/person and age)</i>				
<input type="radio"/>	<input type="radio"/>	6. Ashkenazi Jewish ancestry AND a breast, or pancreatic cancer				
COLON AND UTERINE CANCER						
<input type="radio"/>	<input type="radio"/>	7. Colon OR Endometrial Cancer before age 50? <i>(specify which)</i>				
<input type="radio"/>	<input type="radio"/>	8. Two Family members with the following cancers with 1 under the age 50? colon, uterine, ovarian, stomach, small bowel, kidney/urinary tract, pancreatic, brain <i>(specify cancer w/person and age)</i>				
<input type="radio"/>	<input type="radio"/>	9. Three or more of the following cancers on the same side of your family? colon, uterine, ovarian, stomach, small bowel, kidney/urinary tract, pancreatic, brain <i>(specify cancer w/person and age)</i>				
<input type="radio"/>	<input type="radio"/>	10. Ten or more Colon Polyps # _____				
<input type="radio"/>	<input type="radio"/>	11. Have YOU ever had Uterine/Endometrial Cancer				

X _____ X _____
 Patients Signature Providers Signature Date

Does patient meet criteria for genetic testing? Yes No

If YES, patient was: Tested today Scheduled a consult date _____ Declined _____

(1-5) Integrated BRCA w/Myrisk (6) Multi Site/Reflex (7-9 & 11) Colaris w/Myrisk (10) Colaris AP w/Myrisk

**AFA Obstetrics & Gynecology
Patient Financial Policy**

We have adopted the following financial policy to avoid any misunderstanding between you and this office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about bills or billing pertaining to your care from AFA Obstetrics & Gynecology, please call our billing department at 978-371-1396 option #5.

Please return this form to the receptionist once you have reviewed and signed it. A copy will be provided to you upon your request.

Insurance: We participate with most managed care plans. If you are insured by a plan with which we do not participate, then payment is required at each visit. Your insurance policy is a contract between you and your insurance company and it is your responsibility to know your own coverage. We will process your insurance claim for you if you assign the benefits to us. In other words, you give us permission to bill your insurance company directly and then they will pay us directly. You will be responsible for providing correct insurance information at each visit. You are responsible for obtaining referrals for services if required by your plan. All medical treatment and services that are not covered by your plan will be your responsibility. Patients are responsible for all deductibles, co-payments, non-covered services and out of network services. All co-payments are due at the time of the visit. Ultrasounds and lab work, although they can be performed in our office, are an outside service and therefore bill independently from AFA.

No Insurance Coverage: Full payment is expected at the time of service. We accept Visa, Discover, MasterCard, and checks.

Minor Patients: The adult accompanying the patient and the parent or guardian will be responsible for all services rendered to minor patients.

Delinquent Accounts: Payment is due upon receipt of a statement. If your account becomes delinquent, we will make every effort to collect the debt incurred prior to being sent to a collection agency and possibly being dismissed from the practice.

I have read and fully understand the financial policy and agree to the terms.

Name of Patient (print)

Patient's Date of Birth

Signature of Patient or Guardian

Today's Date

Patient Assignment of Benefits Form

Name: _____ **D.O.B.** _____

Phone number our staff is able to leave detailed medical information: _____

I authorize AFA OB/GYN to release my medical information including office visits, lab results, and treatment plan to the following people:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I authorize AFA OB/GYN to release my medical information to the person(s) listed above which may contain information regarding: (please initial)

_____ STD results, HIV/AIDS testing _____ Drug, alcohol, or mental health treatment

Signature: _____ **Date:** _____

Assignment of Benefits: I assign my benefits to be paid directly to AFA OB/GYN and understand that I am financially responsible for all services that are not covered.

Signature: _____

Release of Information: I authorize AFA OB/GYN to release any information required to process this claim to my insurance company or other party involved in reimbursement for the claim, which may include:

- *Information about genetic testing
- *Information related to communications with a psychotherapist, psychologist, social worker, or other allied mental health professional or human services professional
- *Information about research involving controlled substances
- *Abortion consent forms
- * Mammography records
- *Information about family planning services
- *If I am a minor, information about my treatment and diagnosis (except to my parents)

Signature: _____

HIPAA Privacy Policy: I acknowledge that I have read the practice's Notice of Privacy Practices.

Signature: _____



PATIENT CONSENT FOR MASS HIWAY

The Massachusetts Health Information Highway (Mass HIway) is the secure statewide computer network that allows for the electronic transfer of medical information between healthcare providers that is intended to improve the quality and safety of patient care. I have received and had an opportunity to review the "Mass HIway: Fact Sheet for Patients" provided to me by a physician practice affiliated with Emerson Hospital and Emerson Physician Hospital Organization (the "Practice"). I hereby give the Practice permission to use MassHIway to:

1. Send to the Mass HIway my name, date of birth, gender, email, home address, phone number, and medical record number so that my other providers using Mass HIway know I received care from the Practice and can ask for my medical information when needed for my care.
2. Request, send, and receive my medical information from and to my other providers who also use the Mass HIway. I understand that this information may include information about mental health, HIV test results, sexually transmitted diseases, domestic violence, sexual assault, substance abuse records, reproductive health concerns and genetic testing results.
3. I understand that I may withdraw my permission for the Practice to share information ("Opt-out") at any time by submitting a request in writing. The Opt-out notice can be sent to the Practice.

Print Patient Name

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date of Signature

Print Name of Patient's Legal Representative (if applicable)

Relationship to Patient