☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R.Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

NAME: _____
LAST FIRST DATE OF BIRTH
ADDRESS: _____
STREET CITY STATE ZIP

PHONE (PLACE CHECK WHERE WE MAY LEAVE A MESSAGE, YOU CAN PICK MORE THAN ONE)
HOME☐ _____ WORK☐ _____ CELL☐ _____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐LEGALLY SEPARATED

SOCIAL SECURITY NUMBER: ___-___-___ PHARMACY #: _____

RACE (PLEASE CIRCLE ONE): CAUCASIAN AFRICAN AMERICAN NATIVE AMERICAN CHINESE ASIAN FILIPINO
HISPANIC S. AMERICAN JAPANESE PACIFIC ISLANDER RUSSIAN MULTIRACIAL OTHER: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

EMPLOYER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

_____
EMERGENCY CONTACT #1 PHONE # RELATIONSHIP

_____
EMERGENCY CONTACT #2 PHONE # RELATIONSHIP

INSURANCE POLICYHOLDER NAME: _____
(If same as patient may leave following blank)

DOB: _____ SSN #: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE CARRIER: _____

PLAN TYPE: ☐HMO ☐EPO ☐PPO ☐POS

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

POLICY NUMBER: _____ GROUP # : _____

COPAY/COINSURANCE AMOUNT: _____

SECONDARY INSURANCE? ☐Y ☐N (IF SO, PLEASE PROVIDE A COPY OF ABOVEINFORMATION TO RECEPTIONIST)

Please complete entire form.* ***If something does not apply, please mark N/A.* *Thank you!**

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NAME: AGE: DATE:

REASON FOR VISIT:

FIRST DAY OF LAST MENSTRUAL CYCLE: AGE OF FIRST MENSTRUATION:

ANY PROBLEMS WITH MENSTRUAL CYCLE? AGE OF MENOPAUSE:

ARE YOUR CYCLES REGULAR? ☐Y ☐N HOW MANY PADS/TAMPONS ON HEAVIEST DAY:

ARE YOU CURRENTLY SEXUALLY ACTIVE?: ☐Y ☐N BIRTH CONTROL METHOD USED:

OF PREGNANCIES: _____ # DELIVERIES: _____ # MISCARRIAGES: _____ # ABORTIONS: _____

YEAR	SEX	WEIGHT	VAGINAL OR CESAREAN DELIVERY	COMPLICATIONS

Operations	Year	Other Hospitalizations	Year

***LIST ALL MEDICATIONS AND DOSAGES (INCLUDING OVER THE COUNTER MEDICATION):**

MEDICATION NAME	DOSAGE	DIRECTIONS

***DRUGALLERGIES:**

Please check if you have had any of the following:

Heart disease☐ Hypertension☐ Cancer (Type) _____

Diabetes☐ Hypothyroid☐ Hyperthyroid☐

Migraine Headaches☐ Blood Clotting Disorder☐ Asthma ☐or lung disease☐

High cholesterol ☐ Heart murmur☐ Abnormal Pap☐

Abnormal Mammogram☐ Seizure disorder☐ Liver disease☐

Infertility☐ Herpes☐ Frequent Urinary Infections☐

HIV☐ Other STD☐ Endometriosis☐

Other:

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ARE YOU *CURRENTLY EXPERIENCING* ANY OF THE FOLLOWING?

Urinary incontinence (leakage)☐ Abnormal vaginal discharge☐

Genital warts or lesions☐ Hot flashes☐

Abnormal vaginal bleeding ☐ Pain with intercourse☐

Vaginal dryness☐ Breast discharge or lumps☐

Pelvic or abdominal pain☐ Fever☐

***OTHER SYMPTOMS YOU WOULD LIKE ADDRESSED AT YOUR VISIT TODAY** _____

_____

LAST PAP SMEAR DATE: _____ NORMAL? ☐Y☐ N

LAST MAMMOGRAM DATE: _____ NORMAL? ☐Y ☐ N

LAST ANNUAL LABS DATE: _____ NORMAL? ☐Y ☐ N

IF YOU ARE OVER THE AGE OF 50:
COLONOSCOPY DATE: _____ NORMAL? ☐Y ☐N

BONE DENSITY SCAN DATE: _____ NORMAL? ☐Y ☐ N

FAMILY HISTORY:

MOTHER: LIVING? ☐Y ☐N AGE: ILLNESS: _____

FATHER: LIVING? ☐Y ☐N AGE: ILLNESS: _____

OF BROTHERS: ILLNESS _____ # OF SISTERS: ILLNESS: _____

OTHER FAMILY ILLNESS: _____

SOCIAL HISTORY:

OCCUPATION: _____ ARE YOU: ☐SINGLE ☐LIVING WITH PARTNER ☐MARRIED ☐DIVORCED ☐WIDOWED

TOBACCO USE?☐Y ☐N CIGARETTES PER DAY: _____ HOW LONG? _____

ILLICITDRUGUSE?☐Y ☐N _____

ALCOHOL USE?☐Y ☐N DRINKS/WEEK: _____

EXERCISE REGULARLY? ☐Y ☐N TYPE: _____ DAYS/WEEK: _____

SPECIAL DIET?: _____

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Appointment Policy

We value our patients and the time we spend with each of you and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office 24 hours in advance to cancel or reschedule your appointment. ***Appointments cancelled without a 24 hours advance notice will be charged $25. If you miss more than 3 scheduled appointments, you may be dismissed from the practice.***

_____ _____
Signature of Patient/Guardian Date

_____
Printed Name of Patient/Guardian

Clarification of Medical Visits

In our office, we want to put the patient first by providing outstanding medical care. In order for us to do this, we want to make sure our patients understand our policy for billing your medical visits. If you are scheduled to come in for your annual well woman exam, the doctors will only discuss details or perform services regarding that visit. If there are other medical issues that you would like to discuss that is not considered part of an annual well woman exam, we ask that you schedule another appointment.

If you have an emergent problem, we will address that problem and you will need to reschedule your annual well woman exam. If the problem visit and annual well woman exam is done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you may be held responsible for any out of pocket expenses associated with both services.

If you have any questions or concerns regarding these policies, please ask our staff.

Thank you.

_____ _____
Signature of Patient/Guardian Date

_____
Printed Name of Patient/Guardian

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Policy on Insurance Coverage

We are enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations and restrictions. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Your medical insurance is a benefit that your employer provides for you or you purchase for yourself.

During the course of treatment, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, such as, copays, deductibles and co-insurance will be your responsibility and are due at the time of service.

Understanding your benefits can be confusing and we will do our best to assist you in this area, but keep in mind we have limited access to your medical benefits. Your employer or you have chosen this plan and benefits, not your physician. If YOU do not inform us of any special requirements in your contract, and we subsequently order services, such as labs, pathology or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill YOU directly for those charges.

Your insurance company will never guarantee your benefits to you or to this office. That is why we can only estimate your portion. Regardless of what we calculate as your medical plan benefit, ultimately ***YOU are responsible for the TOTAL cost of your medical treatment.*** If you are unable to pay the estimated portion for your appointment today we will be happy to reschedule it to a later date.

If your insurance company requires a "referral" from your primary care physician, you will be responsible for contacting your primary care physician for the referral (this is the patient's responsibility NOT the responsibility of this office).Treatment rendered by this office without the required referral will serve as your consent for treatment not covered by insurance, and will be payable by you. If we are contracted with your insurance company, your appointment will be rescheduled until a referral can be obtained.

Please check the appropriate boxes:

- ☐ I certify that I have **no insurance** and will be solely responsible for payment in full. (Payment is expected at the time of service)
- ☐ I certify that the insurance reported to this office is a complete and current listing. I understand the office will not submit a claim for any insurance not reported at the time of service.
- ☐ I **DO NOT** have any other insurance coverage other than that which has been provided upon submission of this authorization.

***** You're responsible for providing the correct information regarding which insurance is PRIMARY and SECONDARY. *****

I have read and understood the office policy stated above and agree to accept responsibility as described.

_____ _____
Signature of Patient/Guardian Date

_____
Printed Name of Patient/Guardian

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Consent to Treat Patient

I, _____ (name of patient) have an appointment for an examination and treatment and I give permission to be examined and treated by the following physician.

☐ Kristen N. Innes, M.D., P.A. ☐ Christine V. Ku, M.D., P.L.L.C.☐ Jennifer R.Gulick, M.D., P.L.L.C.

Consent to Treat a Minor

_____ (name of minor) has an appointment for examination and treatment.
I,_____ (parent/legal guardian) give permission for _____(name of minor) to be examined & treated by the following physician. I have accompanied _____ (name of minor) for her visit today.

☐ Kristen N. Innes, M.D., P.A.☐ Christine V. Ku, M.D., P.L.L.C.☐ Jennifer R.Gulick, M.D., P.L.LC.

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLDEGE YOU HAVE READ THE INFORMATION AND SIGN BELOW:

_____ **Assignment of Benefits:**
By signing this form, you authorize payment of medical benefits, including private insurance benefits, directly to Kristen N. Innes, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete your insurance claim. The duration of this consent is definite and continues until revoked in writing

_____ **Acknowledgement of Receipt of Notice of Health Information Practices**
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Kristen N. Innes, M.D., P.A., Christine V. Ku, M.D., P.L.L.C.,and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about your for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

_____ **Acknowledgement of Receipt of Notice of Office Policies and Procedures**
Kristen N. Innes, M.D., P.A., Christine V. Ku, P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver you care. By signing this form, you acknowledge that you have received a copy of our office policies.

_____ **Acknowledgement of ownership interest**
To further our commitment to the quality of surgical care for our patients, Both Dr. Innes and Dr. Gulick have chosen to participate in ownership at Baylor Medical Center at Frisco. Their ownership enhances their ability to direct the manner in which your care is delivered at the facilities. If this is of concern to you, Dr. Innes and Dr. Gulickwill be happy to answer any questions. They are on the medical staff at other healthcare facilities and will be happy to discuss your options of choosing an alternative location. By signing this form, you acknowledge that you have read and understand this disclosure.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **Date:** _____

Thank you for taking the time to fill out this form

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CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name:_____ Date of Birth: _____ Age: _____
Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Health Care Provider: _____

Instruction: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.
You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren.

You and YOUR Family's Cancer History (Please be as thorough and accurate as possible)

	Cancer	YOU Age of Diagnosis	Parents/Siblings/ Children	AGE of Diagnosis	Relatives on your Mother's Side	AGE of Diagnosis	Relatives on your Father's side	AGE of Diagnosis
☒ Y ☐ N	Example: *Breast Cancer*	*45*			*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	Breast Cancer							
☐ Y ☐ N	Ovarian Cancer (*Peritoneal/Fallopian Tube*)							
☐ Y ☐ N	Uterine/Endometrial Cancer							
☐ Y ☐ N	Colon/Rectal Cancer							
☐ Y ☐ N	10 or more LIFETIME COLON POLYPS (*Specify #*)							
	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small Bowel, Sarcoma, Thyroid							
☐ Y ☐ N	OTHER CANCERS (Specify cancer type)							

☐Y ☐N Are you of Ashkenazi decent?

☐Y ☐N Are you concerned about your personal and/or family history of cancer?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

Hereditary Cancer Red Flags (To be competed with your healthcare provider – Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome
- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two Primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome** (see cancer list below)
- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology***before age 60
- ☐ Abnormal MSI/IHC tumor test results (colon/rectal/endometrial/uterine)
- ☐Two or more Lynch syndrome cancer**at any age
- ☐ YOU and one or more relatives with Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome
- ☐Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐Three or more relatives with breast cancer at any age
- ☐ A previously identified BRAC1 or BRAC2 mutation in the family

Lynch Syndrome** (see cancer list below)
- ☐Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: Breast, ovarian and pancreatic
**Lynch syndrome cancer includes: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas
***MSI High histology includes: Muninous, signet ring, tumor infiltrating lymphocytes, crohn"s-like lymphocytic reaction histology, or medullary growth pattern

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____
Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐YES ☐NO ☐Accepted ☐DECLINED
Follow up appointment scheduled: ☐YES ☐NO Date of Next Appointment: _____

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Authorization to Discuss Medical Information

Drs. Innes, Ku and Gulick are committed to quality patient care. We are advocates of maintaining patient confidentially. Our physician policy is to speak only to patients and/or guardians personally in regards to their confidential medical information. Also, we will not leave any confidential medical information on a voice mail system without permission to do so. By filling out this form and signing below, you are giving the physicians at our office permission to communicate more detailed information to other individuals and/or your voicemail. Examples include but are not limited to: your lab and test results, information about your condition, prescription refills or changes, appointment scheduling and/or insurance details.

Our office will keep this consent form in your chart. THIS FORM WILL BE EFFECTIVE UNTIL OTHERWISE NOTIFIED BY THE PATIENT WITH A WRITTEN REQUEST.

Patient Name:_____Date of Birth:_____

Patient Signature:_____Date:_____

I_____(initial) authorize the physicians Dr. Innes, Ku,Gulick and staff to leave a detailed voice message regarding my medical care at the following phone number(s). You may write specific instructions below.

Patient Phone #1_____

Instructions:_____

Patient Phone #2_____

Instructions:_____

I_____(initial) authorize the physician and staff in our office to speak with the following individual(s) about my medical care. You may write instructions below.

Name:_____Relationship:_____Date:_____

Instructions:_____

Name:_____Relationship:_____Date:_____

Instructions:_____

***** I AUTHORIZE RELEASE OF INFORMATION TO INSURANCE COMPANIES AND PAYORS. *****

_____

Signature