JOHN T. ARMSTRONG JR MD INC
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NAPA, CA 94558
(707) 257-4317

FIRST NAME_____LAST NAME_____BIRTHDATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

SOCIAL SECURITY#_____ EMAIL_____

CELL PHONE_____

HOME PHONE_____

WORK PHONE_____

REFERRED BY_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____

SUBSCRIBER NAME_____BIRTHDATE_____

SUBSCRIBER ID #_____SUBSCRIBER GROUP#_____

SECONDARY INSURANCE NAME_____

SUBSCRIBER NAME_____BIRTHDATE_____

SUBSCRIBER ID#_____SUBSCRIBER GROUP#_____

BILLING INFORMATION

RESPONSIBLE PARTY_____ RELATIONSHIP_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE #_____

IN CASE OF EMERGENCY PLEASE CONTACT:_____

PHONE NUMBER:_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Armstrong all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE_____

RELATIONSHIP_____DATE_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____

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.

Example: Colon Cancer *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs* *Cousin 58 yrs*

BREAST AND OVARIAN CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Breast cancer				
Y	N	Ovarian cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Male breast cancer				
Y	N	Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

MELANOMA:

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Melanoma				
Y	N	Pancreatic Cancer				

OTHER CANCERS

		Type of cancer	You	Siblings / Children	Mother's Side	Father's Side
Y	N					

For Office Use Only:

☐ Patient offered genetic testing: ☐ **ACCEPTED** ☐ **DECLINED**

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

BREAST CANCER RISK ASSESSMENT

Patient Name:_____ Date:_____

Instructions: Prior to seeing Dr. Armstrong, please complete the following questionnaire. It will help us assess your risk for developing breast cancer. Thank you.

A. Have you ever had breast cancer? Yes ❒ No ❒

B. Have you ever had a breast biopsy that showed lobular carcinoma in situ (LCIS) or ductal carcinoma in situs (DCIS)? Yes ❒ No or Don't Know ❒

If you checked "yes" to question A or B, you have completed this questionnaire. Please return. Otherwise, please complete the following:

1. What is your race? White ❒ Black ❒ Asian ❒ Hispanic ❒
   Other: _____

2. How young are you? _____

3. How young were you when you had your first menstrual period? _____

4. How young were you when your first child was born? _____
   (If you never had a child, enter "0.")

5. How many 1st degree family members (i.e., mother, sisters, and/or daughters) have had breast cancer? _____

6. Have you ever had a breast biopsy? (A breast biopsy is when the doctor removes tissue from your breast to test for cancer.) Yes ❒ No ❒
   Don't Know ❒

   6a. If yes, how many breast biopsies have you had? _____

7. Did the doctor ever tell you that one or more of your biopsies showed atypical hyperplasia or precancer? Yes ❒ No ❒ Don't Know ❒

Using the Gail Model Risk Assessment tool, your estimated risk for breast cancer is:

a). Within 5 years from now: _____

b). Lifetime: (assuming average life expectancy) _____