



Dear Patient,

We are an Oncology Medical Home (OMH) whose focus is on gynecologic cancers and complex gynecologic issues. Due to the complexity of your diagnosis, your primary care physician has referred you to us. As an OMH we keep our patients informed and involved in their care. No matter your diagnosis, we will not alter our commitment to you nor to our mission of providing quality care at the lowest cost from friendly and compassionate staff. More information about an Oncology Medical Home can be found on our website.

Prior to your first appointment, a nurse navigator will call to provide you with their name and direct phone number. In the coming days and months to follow, should you be uncertain which staff member should assist you with your question or need, your nurse navigator can always be reached to help facilitate this for you.

Included in this packet is your new patient paperwork. Please complete **all documents** prior to your appointment and arrive with these documents, your driver's license, and insurance card, no less than thirty (30) minutes prior to your appointment time. This additional time will provide the front desk the opportunity to transfer this important information into your electronic chart. Educational information, appointment information, and many of your healthcare records can be accessed through our online patient portal at [www.seeyourchart.com](http://www.seeyourchart.com). If you did not access your new patient paperwork through this valuable patient portal, please call and provide your nurse navigator with an email address.

NTGO has four locations. Below is a grid showing where your physician's clinics are throughout the week. Because office locations may provide different services, be sure you are certain of the location of any future appointments.

	Alan Muñoz, M.D.	Thomas Heffernan, M.D.	Abel Morón, M.D.
<b>Monday</b>	Dallas (Park Central)		Medical City of Arlington
<b>Tuesday</b>		Dallas (Park Central)	
<b>Wednesday</b>	Presbyterian Plano		Dallas (Park Central)
<b>Thursday</b>	Dallas (Park Central)	Presbyterian Plano	
<b>Friday</b>		Frisco Square (weeks 1 & 3) Presbyterian Plano (weeks 2 & 4)	Frisco Square (weeks 2 & 4)

**Dallas (Park Central)** 12200 Park Central Dr, Dallas, TX 75251 ♦ One Forest Medical Plaza, Suite 410

**Plano Presbyterian** 6300 W Parker Rd, Plano, TX 75093 ♦ Presbyterian Hospital, Medical Office Building 2, Suite 425

**Medical City of Arlington** 515 W Mayfield Rd, Arlington, TX 76014 ♦ Medical City Hospital, Suite 250

**Frisco Square** 5680 Frisco Square Blvd, Suite 2500, Frisco, TX 75034

Visit our website at [www.northtxgynonc.com](http://www.northtxgynonc.com) for maps and addresses

## Welcome to North Texas Gynecologic Oncology

### At your first appointment, bring:

- Driver's License
- Insurance Card
- New Patient Packet, completed

**Arrive 30 minutes prior to appointment time**

## NEW PATIENT MEDICAL HISTORY



PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

**PAST MEDICAL HISTORY** — *Indicate any of the following that apply*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Underactive Thyroid (Hypothyroidism)            | <input type="checkbox"/> High Cholesterol (Hyperlipidemia) | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Coronary Artery Disease         |
| <input type="checkbox"/> Heart Attack (Myocardial Infarction)            | <input type="checkbox"/> Peripheral Vascular Disease       | <input type="checkbox"/> Congestive Heart Failure           | <input type="checkbox"/> Atrial Fibrillation             |
| <input type="checkbox"/> Deep Vein Thrombosis                            | <input type="checkbox"/> Pulmonary Embolism                | <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> COPD                            |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Osteoporosis                      | <input type="checkbox"/> Lumbar Disk Disease                | <input type="checkbox"/> Frequent Urinary Infections     |
| <input type="checkbox"/> Renal Failure <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney Stones                     | <input type="checkbox"/> Upper or Lower GI Bleed            | <input type="checkbox"/> Fibrocystic Breast Disease      |
| <input type="checkbox"/> Ulcerative Colitis                              | <input type="checkbox"/> Crohn's Disease                   | <input type="checkbox"/> Irritable Bowel Syndrome           | <input type="checkbox"/> Cirrhosis                       |
| <input type="checkbox"/> Hepatitis                                       | <input type="checkbox"/> Seizure Disorder                  | <input type="checkbox"/> CVA (Stroke)                       | <input type="checkbox"/> TIA (Transient Ischemic Attack) |
| <input type="checkbox"/> Peripheral Neuropathy                           | <input type="checkbox"/> Depression                        | <input type="checkbox"/> Schizophrenia                      | <input type="checkbox"/> Bipolar Disorder                |
| <input type="checkbox"/> Rheumatoid Arthritis                            | <input type="checkbox"/> Auto Immune Disorder(s) _____     |   | <input type="checkbox"/> HIV / AIDS                      |
| <input type="checkbox"/> HPV   | <input type="checkbox"/> Herpes                            | <input type="checkbox"/> Gonorrhea / Chlamydia              | <input type="checkbox"/> Syphilis                        |

**GENETIC TESTING?** Have you or a family member ever had Genetic Testing?  Yes  No

If yes, please complete type of test: **BRCA**    \_\_\_Positive \_\_\_Negative

**Lynch Syndrome** \_\_\_Positive \_\_\_Negative

**PAST SURGICAL HISTORY** — *Indicate any of the following surgeries that apply*

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Tonsillectomy   | <input type="checkbox"/> Adenoidectomy  | <input type="checkbox"/> Cataract Surgery                             | <input type="checkbox"/> Thyroidectomy                         |
| <input type="checkbox"/> Cervical Disk Fusion  | <input type="checkbox"/> Pacemaker Insertion  | <input type="checkbox"/> Coronary Bypass Stenting                     | <input type="checkbox"/> Coronary Artery Bypass Graft          |
| <input type="checkbox"/> Exploratory Laparotomy  | <input type="checkbox"/> Exploratory Laparoscopy  | <input type="checkbox"/> Appendectomy                                 | <input type="checkbox"/> Gallbladder Removal (Cholecystectomy) |
| <input type="checkbox"/> Removal Spleen (Splenectomy)  | <input type="checkbox"/> Stomach Removal (Partial Gastrectomy)                              | <input type="checkbox"/> Surgery for Aneurysm (Aneurysmectomy)        | <input type="checkbox"/> Femoro-Popliteal Bypass               |
| <input type="checkbox"/> Varicose Vein Stripping   | <input type="checkbox"/> Inguinal Hernia Repair (Inguinal Herniorraphy)                     | <input type="checkbox"/> Ventral Hernia Repair (Ventral Herniorraphy) | <input type="checkbox"/> Hemorrhoidectomy                      |
| <input type="checkbox"/> Hysterectomy – partial, ovaries were NOT removed (ovarian preservation) | <input type="checkbox"/> Hysterectomy – total, ovaries WERE removed (salpingo oophorectomy) | <input type="checkbox"/> C-Section                                    | <input type="checkbox"/> Tubal Ligation (tubes tied)           |
| <input type="checkbox"/> Organ Transplant  | <input type="checkbox"/> Other: _____   |   |  |

**PAST CANCER HISTORY** — *Indicate any of the following cancers that apply*

- None     Breast     Cervix     Ovaries     Uterus     Colon     Lung     Other: \_\_\_\_\_

**GYNECOLOGIC HISTORY**

**MENSTRUAL HISTORY**

Age of first menstrual period: \_\_\_\_\_

Age of Menopause (if applicable): \_\_\_\_\_

Date of Last Menstrual Period: \_\_\_\_\_

Describe your periods:

- Regular  
 Irregular

Menstrual flow is (was) typically:

- Light  
 Normal  
 Heavy

**HORMONE THERAPY**

Never     Current     Previous (date stopped): \_\_\_\_\_

Number of years used? \_\_\_\_\_    Type: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**CONTRACEPTIVE (birth control)** **Oral Contraceptive Methods:**  
 Never  Current  Previous (date stopped): \_\_\_\_\_  
 Number of years used? \_\_\_\_\_ Type: \_\_\_\_\_

**Other Contraceptive Methods: (not including Condoms)**  
 Never  Current  Previous (date stopped): \_\_\_\_\_  
 Number of years used? \_\_\_\_\_ Type: \_\_\_\_\_

**MATERNITY** Number of Pregnancies \_\_\_\_\_ Number of Births \_\_\_\_\_ Age at first full-term pregnancy \_\_\_\_\_

**HYSTERECTOMY** Have you had a hysterectomy:  Yes  No *If answered Yes:* Do you have  One *or*  Both ovaries?  
 Do you still have a cervix?  Yes  No  Unsure

## SOCIAL HISTORY

**BLOOD TRANSFUSIONS** If necessary, will you accept blood during surgery?  Yes  No

**TOBACCO use**  Never  Current Every day smoker  Current Some Day smoker  Heavy tobacco smoker  Light tobacco smoker  
 Pipe smoker  Chew Tobacco  Moist powdered tobacco  Snuff  E-cigarettes  Former smoker  
 Previous (date stopped): \_\_\_\_\_ Number of years used? \_\_\_\_\_ # packs per day: \_\_\_\_\_

**ALCOHOL use**  Never  Occasionally  Previous Number of years? \_\_\_\_\_  
 On average, how many drinks per: Day \_\_\_\_\_ Week \_\_\_\_\_ Type:  Wine  Beer  Spirits

**DRUG use** *Do you use illicit drugs?*  Yes  No Type: \_\_\_\_\_

**MARITAL STATUS**  Single  Partnered  Married  Separated  Divorced  Widowed

**CHILDREN**  No Children  Yes, I have \_\_\_\_\_ living children

**Your OCCUPATION**  Retired  Homemaker  Other: \_\_\_\_\_

## FAMILY MEDICAL HISTORY

**Mother**  Alive, age \_\_\_\_\_  Deceased at age \_\_\_\_\_, cause of death: \_\_\_\_\_

**Father**  Alive, age \_\_\_\_\_  Deceased at age \_\_\_\_\_, cause of death: \_\_\_\_\_

**Siblings** *Number of:* Living Brothers: \_\_\_\_\_ Living Sisters: \_\_\_\_\_ Deceased Siblings: \_\_\_\_\_

**FAMILY CANCER HISTORY**  
 None  Unknown  Breast  Ovarian  Lung  Pancreatic  Colon  Prostate  Thyroid  Melanoma  
 Neurofibromatosis  Familia Adenomatous Polyposis (FAP)  Other:

**FAMILY DISEASE HISTORY**  
 None  Unknown  High Blood Pressure (Hypertension)  Diabetes  Coronary Artery Disease  
 High Cholesterol (Hyperlipidemia)  Other:

## HEALTH MAINTENANCE HISTORY

**Colonoscopy**  Never  Date of last: \_\_\_\_\_ with Dr. \_\_\_\_\_  Scheduled for \_\_\_\_\_

**Mammogram**  Never  Date of last: \_\_\_\_\_ with Dr. \_\_\_\_\_  Scheduled for \_\_\_\_\_

**Pap Smear**  Never  Date of last: \_\_\_\_\_ with Dr. \_\_\_\_\_  Scheduled for \_\_\_\_\_

Most recent **Flu vaccine** (month/year) \_\_\_\_\_

Have you had a **Pneumonia vaccine** this year?  NO  YES (date) \_\_\_\_\_

Have you had the **Gardasil vaccine** series?  NO  YES (dates) \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**DRUG ALLERGIES** — *list any medication allergies below*

Medication	Reaction
1.	
2.	
3.	

**FOOD ALLERGIES** — *list any food allergies below*

Food	Reaction
1.	
2.	
3.	

**MEDICATIONS** — *list all medications you are currently taking including supplements*

Name of Drug	Dosage Amount	Frequency Taken
1.	mg or mcg	# ____ taken ____ times daily or every ____ hours
2.	mg or mcg	# ____ taken ____ times daily or every ____ hours
3.	mg or mcg	# ____ taken ____ times daily or every ____ hours
4.	mg or mcg	# ____ taken ____ times daily or every ____ hours
5.	mg or mcg	# ____ taken ____ times daily or every ____ hours
6.	mg or mcg	# ____ taken ____ times daily or every ____ hours
7.	mg or mcg	# ____ taken ____ times daily or every ____ hours
8.	mg or mcg	# ____ taken ____ times daily or every ____ hours
9.	mg or mcg	# ____ taken ____ times daily or every ____ hours
10.	mg or mcg	# ____ taken ____ times daily or every ____ hours

**PHARMACY** — *Complete all information of your pharmacy*

Pharmacy Name	Address	Phone#
_____	_____	_____
	_____	

# FAMILY HISTORY QUESTIONNAIRE

## for Common Hereditary Cancer Syndromes



PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

Age at first period \_\_\_\_\_ Age at first full term pregnancy \_\_\_\_\_

Have you had a surgical or needle biopsy of the breast? YES NO

If yes, did the biopsy show atypical cells? YES NO UNKNOWN

Are you menopausal? YES NO

Have you ever used Hormone Replacement Therapy? YES NO

Has anyone in your family had genetic testing for a hereditary cancer syndrome? YES NO

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 cousin.

### BREAST AND OVARIAN CANCER (BRCA)

			YOU (age of diagnosis)	Siblings/Children (age of diagnosis)	Mother's side (age of diagnosis)	Fathers side (age of diagnosis)
YES	NO	<i>Example: Colon Cancer</i>		<i>Brother at 36</i>	<i>Aunt at 44</i>	<i>Grandfather at 65 Cousin at 58</i>
		Breast Cancer				
		If yes above, was Tamoxifen or Herceptin prescribed?				
		Breast cancer in both breasts or multiple primary breast cancers				
		Ovarian Cancer				
		Male Breast Cancer				
		Prostate Cancer (BRCA)				
		Pancreatic Cancer (Col/BRCA)				
		Melanoma (BRCA)				
		Are you of Ashkenazi Jewish decent?				

### COLON and UTERINE CANCER (Colaris)

		Uterine (endometrial) Cancer				
		Colon Cancer				
		Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer. (Please circle type of cancer)				
		Pancreatic Cancer (Col/BRCA)				

**For Office Use Only:**

Confirmed Triple Negative Status	YES	NO		
Patient meets NCCN criteria for testing	YES	NO		
Patient offered hereditary cancer testing	YES	NO	If Yes: accepted declined	Reason:
Follow-up appointment scheduled	YES	NO	Appt Date:	Date:
Health Care Provider's Signature				

## AUTHORIZATION FOR RELEASE OF INFORMATION



PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

I hereby authorize NTGO to release copies of my medical records to \_\_\_\_\_.

I hereby authorize \_\_\_\_\_ to release information and my medical records to NTGO.

Restrictions: (none if left blank)

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the information to be released contains any information about HIV/AIDS, an additional HIPAA release of medical information may be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.

**COMMUNICATION PREFERENCES**

*(Indicate all that apply)*

	Leave message with <b>detailed information</b>	Leave message with <b>call-back number only</b>
Home Phone	<input type="checkbox"/>	<input type="checkbox"/>
Cell Phone	<input type="checkbox"/>	<input type="checkbox"/>
Work Phone	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
PATIENT / REPRESENTATIVE SIGNATURE

\_\_\_\_\_  
TODAY'S DATE

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**PATIENT FINANCIAL RESPONSIBILITY**

Thank you for choosing North Texas Gynecologic Oncology to serve your healthcare needs. Our physicians and staff look forward to providing excellent care to you and will work hard toward keeping the financial portion of your



visit clear, up-to-date and concise. To better understand how you can assist us in accomplishing this goal, please read the information below.

1. **INSURANCE CARDS:** Please be prepared to show the receptionist your **current** insurance card each time you come to our office so we can verify our system contains up-to-date information.
2. **COPAYMENTS, DEDUCTIBLES and CO-INSURANCE BALANCES:** Many insurance companies require a copayment for each date of service. NTGO has a contractual obligation with your insurance company to collect this copayment. ***If your insurance plan requires you to pay a copayment, co-insurance and/or deductible, please be prepared to do so at the time of service unless other arrangements have been made.*** Once your claim is filed, the insurance company will pay the portion of the claim they are contractually obligated to pay and the balance will be the responsibility of the insured. You will receive a monthly statement showing your balance as of the date the statement was printed. If your next appointment at our office is prior to the due date, you can choose to pay your balance in our office. Alternatively, you can pay your balance by mailing us a check or using the online feature at northtxgynonc.com.
3. **CHANGES IN INSURANCE:** Insurance plans can change during the year due to employers changing plans or employees changing jobs. ***Should your insurance plan change, please contact the business office immediately. In the event you undergo chemotherapy treatment, please understand that an insurance company may take a couple of weeks to approve a treatment.*** If we are not given ample notification of a change in insurance, your treatment could be delayed or you could be financially responsible for any unpaid services.
4. **COBRA:** If you should lose your insurance and are planning on converting to a COBRA plan, please notify us immediately to avoid potential delays in your office visit, surgery or treatment.
5. **INSURANCE CORRESPONDANCE:** Information received in the mail from your insurance company should always be responded to quickly and completely. Failure to respond to an insurance inquiry may delay payment of services. Should you need help in understanding or completing the inquiries, please ask to speak with someone in our business office.
6. **Referrals and Authorizations:** Please be aware your insurance plan may require a referral or authorization for us to provide services to you. If you do not provide this information to us prior to your appointment, our office will be unable to bill your insurance company for services provided and you will be held responsible for them.
7. **PAYMENT PLANS:** If you are unable to pay your statement in full each month, a payment plan may be approved for you. If it is determined you are in need of a payment plan, please honor your payment agreement to avoid potential visit, surgery or treatment delays.
8. **MEDICARE INFORMATION AVAILABLE:** If you are eligible for Medicare, or will become eligible in the coming year, please ask someone in our business office for additional information on the benefits of enrolling in Medicare even if you and your spouse are currently working and receiving commercial insurance.
9. **ABN:** In the event your insurance company does not cover certain services recommended by our physicians, you may be requested to sign an ABN (Advanced Beneficiary Notice) and pay for these services out of pocket.
10. **UNDERSTANDING YOUR INSURANCE:** The business office will work diligently towards making the financial part of your treatment go smoothly; however, it is important for you, as the patient, to understand your policy and coverage as services not covered by your insurance are your financial responsibility.
11. **SELF-PAY:** Self-pay patients should be prepared to pay the full office visit amount, including any additional services performed during the office visit, at the time of check out.
12. **RETURN CHECK FEE:** A \$25.00 return check fee will be added to your balance for any non-paid payment received.
13. **REFUNDS:** Refunds are issued when an overpayment has been identified. If you feel a refund is due, please contact us.

*By signing below, you indicate you have been made aware of your financial responsibilities.*

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
STAFF INITIALS

\_\_\_\_\_  
DATE