



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, Carespace. 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 to receive a link to log on.

NTGO has three 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.
Monday	Dallas (Park Central)	
Tuesday		Dallas (Park Central)
Wednesday	Presbyterian Plano	
Thursday	Dallas (Park Central)	Presbyterian Plano
Friday		Presbyterian Plano

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

Visit our website at 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

ADVANCED DIRECTIVE Living Will: Yes No Power of Attorney: Yes No Do Not Resuscitate: 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 Current: _____ Unemployed

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) Endometrial Other:

FAMILY MEDICAL 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 _____

Have you had a **Flu vaccine** this year? YES (date) _____ NO

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

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

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:

Health Care Provider's Signature

Date:

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 detailed information	Leave message with call-back number only
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

DISTRESS THERMOMETER

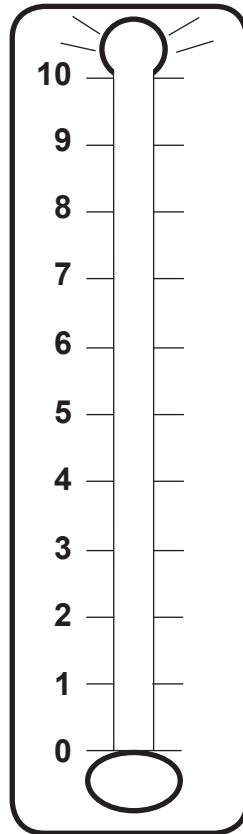
NAME _____

DATE OF BIRTH _____

TODAY'S DATE _____

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

Indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

- | YES | NO | <u>Practical Problems</u> | YES | NO | <u>Physical Problems</u> |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Child care | <input type="checkbox"/> | <input type="checkbox"/> | Appearance |
| <input type="checkbox"/> | <input type="checkbox"/> | Housing | <input type="checkbox"/> | <input type="checkbox"/> | Bathing/dressing |
| <input type="checkbox"/> | <input type="checkbox"/> | Insurance/financial | <input type="checkbox"/> | <input type="checkbox"/> | Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Transportation | <input type="checkbox"/> | <input type="checkbox"/> | Changes in urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Work/school | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment decisions | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| | | <u>Family Problems</u> | <input type="checkbox"/> | <input type="checkbox"/> | Eating |
| <input type="checkbox"/> | <input type="checkbox"/> | Dealing with children | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Dealing with partner | <input type="checkbox"/> | <input type="checkbox"/> | Feeling swollen |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to have children | <input type="checkbox"/> | <input type="checkbox"/> | Fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | Family health issues | <input type="checkbox"/> | <input type="checkbox"/> | Getting around |
| | | <u>Emotional Problems</u> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Memory/concentration |
| <input type="checkbox"/> | <input type="checkbox"/> | Fears | <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Sadness | <input type="checkbox"/> | <input type="checkbox"/> | Nose dry/congested |
| <input type="checkbox"/> | <input type="checkbox"/> | Worry | <input type="checkbox"/> | <input type="checkbox"/> | Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of interest in usual activities | <input type="checkbox"/> | <input type="checkbox"/> | Sexual |
| | | <u>Spiritual/religious concerns</u> | <input type="checkbox"/> | <input type="checkbox"/> | Skin dry/itchy |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Sleep |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Tingling in hands/feet |

Other Problems: _____