☐ 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

Existing Patient History

Last Name: First Name: DOB :

Address

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Home phone: ☐ OK to leave a detailed message

Cell phone: ☐ OK to leave a detailed message

Email:

Last menstrual cycle: Method of Birth Control:

Are you currently sexually active?: ☐Y ☐N

New medications or supplements since previous visit:

List any medical diagnosis, hospital admissions, or problems since last visit:

Last Mammogram: Normal? ☐ Y ☐ N Last Colonoscopy:

Last Bone Density Scan Normal? ☐ Y ☐ N Last Annual Labs:

Reason for visit:

*List all Medications and Dosages (including over the counter medication):

Medication Name	Dosage	Directions

Emergency Contact: Phone #: Relation:

Insurance Guarantor: DOB: SSN #:

Address: City: State: Zip:

Home phone: Cell Phone:

Pharmacy Name: Pharmacy Phone:

Pharmacy Address: Pharmacy FAX:

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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 at least 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.**

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.

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.

______________________ ______________________ ______________

Printed Name of Patient/Guardian | Signature of Patient/Guardian | Date

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FAMILY HISTORY QUESTIONNAIRE

GENESCREEN

GENETIC COUNSELING

PATIENT INFORMATION

Patient Name:______________________________________ DOB: ______/ _______/ _______

Are you adopted? No________ Yes_______

What is you ethnic background? (ex: African, Ashkenazi Jewish, Italian) ______________________________

FAMILY HISTORY

Please make below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship in the appropriate column.

Cancer Type	Self	Siblings	Family Member Mothers Side	Family Member Father's Side
Bone Cancer				
Breast Cancer – Male				
Breast Cancer Before Age 60				
Colorectal Cancer Before Age 50				
Melanoma + Another Cancer Discussed in this Form				
Melanomas in an individual – Two or More				
Ovarian Cancer				
Pancreatic Cancer				
Soft Tissue Cancers (fat, muscle, nerves, fibrous, tissues, blood vessels, or deep skin tissues)				
Stomach, Kidney/Urinary Tract, Brain or Small Bowel Cancer				
Uterine Cancer Before Age 50				
Other Cancer: Please List Any That Have Not Been Mentioned.				

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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