Lawrence Koning, M.D., Inc.
Corona Women's Healthcare Pavilion

Primary Language:_____

Name (last, first, initial): _____Date of Birth:_____Age:_____
Address:_____City:_____State_____Zip:_____
Cell Phone:_____Marital Status: **S M Sep D W** E-mail:_____
Other Phone:_____**May we contact you or leave message at the above phone and address?**_____
SS#:_____Driver's Lic#_____Occupation:_____
Employer:_____Bus. Address:_____
Bus. Phone:_____**May we contact you at work?**_____ Maiden Name:_____
Spouse/Partner Name:_____Phone#:_____DOB:_____
Name of your Primary/Family Doctor:_____
Who referred you to our office?_____

Emergency Contact NOT Living With You

Name:_____Relationship:_____
Address:_____Phone:_____

Nearest Relative (Other than Spouse/Partner)

Name:_____Relationship:_____
Address:_____Phone:_____

Insurance Information

PRIMARY INSURANCE:
Name of Policy Holder:_____Relationship:_____
Name of Primary Ins:_____ID#_____
Insured/Responsible Party Name:_____SS#_____D.O.B._____

SECONDARY INSURANCE:
Name of Policy Holder::_____Relationship:_____
Name of Secondary Ins:_____ID#_____

RELEASE OF INFORMATION: I hereby authorize any insurance company, repayment organization, employer, hospital, physician or any healthcare provider to release all necessary medical records or medical information, and information with respect to myself, to Dr. Lawrence K. Koning that may have a bearing on the benefit payable under this or any other plan providing benefits or services, including the dollar balance of benefits remaining under any applicable lifetime maximum benefits provision, or that which may have a bearing on my medical condition.

ASSIGNMENT OF BENEFITS: I hereby authorize Dr. Lawrence K. Koning to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment directly to Dr. Lawrence K. Koning for any benefits otherwise payable to me for all claims for such services or submitted prior to, or after, the date provided on this form. **I understand that it is my responsibility to inform Dr. Lawrence K. Koning of any changes in my insurance coverage and to be knowledgeable of my benefits. I understand that I am financially responsible for payment for all services rendered and that I am obliged to pay all charges denied by my insurance carrier.** This assignment in no way releases me from said responsibility and imposes no obligation on Dr. Lawrence K. Koning to collect money on my behalf.

I have read, understand and agree to all of the above. A photocopy of this agreement may be used as though it were an original. This release of Information and Assignment of Benefits will be effective until revoked by me in writing.

Patient/Guardian:_____Date:_____Updated_____
Updated_____

Lawrence Koning, M.D., Inc.
Corona Women's Healthcare Pavilion
Obstetrics and Gynecology

CONFIDENTIAL PERSONAL HEALTH INVENTORY

Patient Name:_____ **Age:**_____ **Date:**_____
Present Problem is:_____

MENSTRUAL HISTORY: Check (x) yes or no. Fill in blank spaces where appropriate.

1. Do you menstruate? Yes____No____
2. Menstruated first time at age of _____
3. Last menstrual period occurred on_____
4. Was your last menstrual period normal? Yes____No____
5. Up to this time periods have been: Regular____Somewhat Irregular___Completely Irreg____
6. The interval between periods ranges in length from_____to_____days.
7. Menstrual flow usually lasts for a total of _____days.
8. Menstrual flow is usually: Scant____Moderate____Heavy____Excessive_____
9. Do you usually have clots with your periods? Yes_____No_____
10. Are your periods usually painful? Yes____No___
11. If painful, are they Mild_____ Moderate_____Severe_____Incapacitating_____
12. Do you ever have spotting or bleeding between periods? Yes_____No_____
13. Do you ever have any bleeding or spotting following sexual intercourse? Yes____No_____
14. Do you ever have any pain with sexual intercourse? Yes_____No_____
15. Do you ever have any vaginal discharge? Yes____No____
16. Have you ever had a pap smear? Yes_____No_____
17. Last pap smear? Date_____ Place_____Result: Normal_____Abnormal_____
18. Have you missed periods without being pregnant? Yes_____No_____ How many?_____
19. If not menstruating, stopped at age of _____
20. Have you had any bleeding or spotting since periods stopped? Yes_____No_____
21. Do you have any hot flashes? Yes_____No_____
22. Do you use alcohol? Yes_____No_____; if Yes how much?_____
23. Do you use tobacco? Yes_____No_____; if Yes how much?_____
24. Please list the medications you are now taking:_____

_____

25. Have you ever had any reaction or side effects from drugs, vaccines, chemicals or any other agents? Yes_____No_____; if Yes please explain:_____

_____

26. Do you use contraception? Yes_____No_____; if Yes which type?_____

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CONFIDENTIAL PERSONAL OBSTETRIC HISTORY

PREVIOUS PREGNANCIES:
Please give all the information in regard to your previous pregnancies by filling out the spaces below. If information is unknown, leave space blank.

Year of birth or miscarriage	Birth Weight of Infant	Complications

PAST MEDICAL HISTORY

Please circle any of the following medical diagnoses you've had:

Diphtheria	Heart Disease	Kidney Disease	Epilepsy	Asthma
Scarlet Fever	Hypertension	Diabetes	Syphilis	Hay Fever
Rheumatic Fever	Thyroid Disease	Blood Transfusion	Gonorrhea	Drug Sensitivity
Varicosities	Thrombophlebitis	Accidents	Tuberculosis	Pneumonia
Cancer	Jaundice	Hepatitis	Injuries	Anemia

Please explain any other major illnesses:

PAST SURGICAL HISTORY

Please circle and Date any of the following surgical procedures you've had:

Appendix	Date:	Hernia	Date:	Hysterectomy	Date:
Gall Bladder	Date:	Chest	Date:	Vaginal repair	Date:
Kidney stones	Date:	Spine	Date:	C-section	Date:
Tonsils	Date:	Breast	Date:	D and C	Date:
Tumor	Date:	Ovary	Date:	Varicose vein	Date:
Tubal	Date:	Other:			

FAMILY MEDICAL HISTORY

Please circle any of the following that a family member has been treated for:

TUBERCULOSIS HIGH BLOOD PRESSURE DIABETES CANCER HEART DISEASE

REVIEW OF SYSTEMS:

Current Medication List

Name: _____ Date of Birth: _____/_____/_____

Pharmacy name:	
Pharmacy location:	
Known medication allergies:	
Family Physician name:	

Medications I take
(prescription, non-prescription, vitamins, herbal supplements)

What I take	Why I take it	When I take it	Special instructions

The accuracy of the information in this document depends on the accuracy and completeness of information provided by the patient at the time this document was prepared. The patient is responsible for advising the pharmacist of any change to these medications

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

Instructions: 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 #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐Y ☐N Are you of Ashkenazi Jewish descent?

☐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 completed 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 result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a 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 *BRCA1* or *BRCA2* 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 cancer*

**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: *Mucinous, 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:_____

LAWRENCE KONING, M.D. INC.
OBSTETRICS & GYNECOLOGY

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Signature

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ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dr. Lawrence Koning's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had to opportunity to receive a copy of the Notice of Privacy Practices.

Patient Name:_____ Date:_____

Signature:_____

A COPY OF OUR PRIVACY PRACTICES ARE AVAILABLE UPON REQUEST.

IF YOU WISH TO BE CONTACTED CONFIDENTIALLY, PLEASE INFORM THE RECEPTIONIST.

THANK YOU.