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.

PATIENT OBSTETRICAL HISTORY

Please answer the following questions:

MENSTRUAL HISTORY:

How old were you when you started your period?_________

How often do you have a period?______________

How long do they last?___________________

First day of your last period?__________________Was it normal?___________________

How many pregnancies have you had?________

YOUR PRIOR MEDICAL HISTORY?

Have you ever had or been treated for any of the following? Check all those that apply.

Kidney disease______

Heart disease______

High Blood Pressure_____

Rheumatic fever______

Tuberculosis_______

German Measles______

Anxiety/Depression______ Are you currently on any medication?_________

Diabetes_______

Varicosities, Phlebitis, Varicose Veins_____

Asthma_____

Blood Transfusions_______

Herpes______

Chlamydia_______

HPV______

Gonorrhea______

Syphilis______

Abnormal Pap Smears______

Thyroid dysfunction________

Epilepsy (seizures)________

Blood Disorders__________

Do you use tobacco? Yes______No____If yes, how often?_____________

Do you drink alcohol? Yes_____No____If yes, how often?_____________

Do you have cats at home? Yes_____No_____

Have you used street drugs before or during this pregnancy? Yes_____No______

ALLERGIES:

Do you have any known allergies? _________________________________

Do you take allergy medication? ______________________________

Are you allergic to any ***medications?*** If so which drugs?____________________________

SURGICAL HISTORY:

Have you had any surgical procedures? Please give names and dates for each procedure:____

Have you had any accidents? Please give dates and describe:_________________________

____

FAMILY MEDICAL HISTORY:

Please circle if anyone in your family has been treated for the following:

TUBERCULOSIS HIGH BLOOD PRESSURE HEART DISEASE DIABETES
EPILEPSY ALLERGIES MULTIPLE BIRTHS BIRTH DEFECTS

PREGNANCY HISTORY: Is this your first pregnancy?_____________

#	Date	Duration of Pregnancy	Hours of Labor	Type of Delivery	Weight	Complications?

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GENETIC SCREENING QUESTIONAIRE

Patient Name:_______________________________________ **Date**__________________

1. How many times have you been pregnant including this pregnancy?_______________

2. How many live born babies have you had?_____________________________________

3. Have you ever had a miscarriage?____

4. Have you ever had a stillborn?____

5. Are all of your children still living?____

6. Were any of your children born with birth defects?______________________________

7. Will you be 35 or older when your baby is born?________________________________

8. Is anyone in your family or the baby's father's family intellectually impaired?___________

9. Has anyone in your family or the baby's father's family had a child with birth defects?____

10. Is there any disease that "runs" in either family?________________________________

11. Are you or the baby's family of Eastern European Jewish origin (Ashkenazi)?____

12. Are you or the baby's father black?____

13. Are you or the baby's father of Italian or Greek origin?___________________________

14. If your baby's father has children with another woman, did she have miscarriages, still-births, children who died, or children with birth defects?____________________________

15. What is your ethnic background?_________________Baby father's?________________

LAWRENCE KONING, MD, INC, F.A.C.O.G.
BOARD CERTIFIED IN OBSTETRICS & GYNECOLOGY

RE: OBSTETRIC FEES

Dear OB Patient,

My fee for total obstetric care (global fee) is $2500 for normal vaginal delivery and $2700 for C-section, if needed. These fees include Dr. Koning's services during and related to your pregnancy, delivery and post partum. (6 weeks vaginal delivery and 8 weeks caesarean section).

Cash arrangements can be made with our billing manager.

The following is **not** included in this fee:

1. Ultrasounds
2. Laboratory Tests
3. Non-stress tests (NST's)
4. Hospital fees
5. Fetal Monitoring
6. Pediatrician fees
7. Anesthesiologist (Epidural, etc.)
8. Office visits unrelated to routine OB care.
   (i.e.: colds, urinary tract infections, other illnesses or conditions)

Your insurance company will be contacted to verify eligibility and benefits for prenatal care. **You will be responsible to pay, in advance, any deductibles and/or coinsurance amounts that are required by your contract with your insurance company. These contract portions must be paid by your seventh month (28 weeks) of pregnancy.**

My office staff will discuss your benefits and arrange for payments.

Sincerely,
Lawrence Koning, M.D.

I have read and understand that my medical coverage is a contract between my insurance company and myself. I am responsible for any deductibles and coinsurance amounts set for the by my insurance company. I will make arrangements to have my portion paid by my seventh month (28 weeks) of pregnancy. I also agree that if my insurance coverage status changes at anytime, I will inform the office immediately.

Signed:__________________________________**Dated**______________________

Insurance Company:____

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.

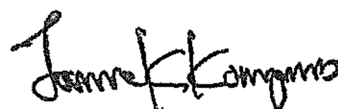
Call the Office When I Do Not Hear the Results of Labs and Other Tests

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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Corona Women's Healthcare Pavilion
Obstetrics and Gynecology

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.