# Ducharme General Surgery, PLLC

## PATIENT REGISTRATION FORM

________________________________________ Date ____________________

Patient Name:________________________________________________________ M_____ F _____
Last First Legal Nickname MI

Is this your legal name? Yes_____ No_____ If no, what is your legal name? ____________________

Marital Status: Single_____ Married_____ Divorce_____ Widow_____ Spouse's Name: ____________________

Street Address:________________________________ PO Box:______________ Apt/Suite:________

City:______________________ State:________ Zip Code:__________ Phone # ______________

Date of Birth:______________ Age:_______ Social Security #:______________ Cell #: ______________

Email:______________________ Race:______________________ Language:______________________

Your Employer:______________________ Phone#______________ Occupation:______________________

Primary Care Physician:________________________________ Phone #: ______________________

Referring Physician (if different)______________________ Phone #: ______________________

Pharmacy Name and Address:________________________________ Phone #: ______________

## INSURANCE INFORMATION

**Are you covered by health insurance**? Yes_____ No_____ **If No, please make payment arrangements with our business office.**

Primary Insurance________________________________ Policy #______________ Group # __________

Policy Holder Name________________________________ Policy Holder Date of Birth ______________

Social Security Number________________________________ Copay______________________

Secondary Insurance________________________________ Policy #______________ Group # __________

Policy Holder Name________________________________ Policy Holder Date of Birth ______________

Social Security Number________________________________ Copay______________________

If this visit related to an at work injury? Yes_____ No_____ If yes, Employer at time of injury ______________

Date of Injury______________ Insurance Info______________________ Claim # ______________

## EMERGENCY CONTACT

Emergency Contact________________________________ Relationship to Patient ______________

Phone #______________________ Cell #______________________ Date of Birth ______________

**ALL PATIENTS**

**PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS**

"I hereby authorize Ducharme General Surgery, PLLC to release to or to request from any insurance company, other physician or hospital, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care, including any financial information. This information may be faxed or sent electronically. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due on any pending insurance claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account to collections, I will be liable for the reasonable collection fees and court costs expended therein." I understand that there is a $35 pre-paid fee for all disability forms filled out by the physician. The organization reserves the right to charge interest on unpaid accounts.

PATIENT SIGNATURE:________________________________________ DATE: ______________
(Or parent/guardian if patient is a minor)

DUCHARME
General Surgery PLLC

Name: ______________________ Age: ________ Sex: _______
Referring Physician: ______________________________
Primary Care Physician: ______________________________________________
Preferred Pharmacy Location: ___________________________________
Reason for today's visit: _____________________________________

Current Height__________________Current Weight_____________________Weight one year ago ____________________

**Current and Past Medical Problems: (please circle Yes or No)**

| | | |
|---|---|---|
| **Yes** | **No** | **Diabetes – when were you diagnosed?** |
| **Yes** | **No** | **Heart Disease – if yes, what type?** __________________________ |
| **Yes** | **No** | **Angina (chest pain)** |
| **Yes** | **No** | **High Blood Pressure** |
| **Yes** | **No** | **Stroke – when?**____________**Any paralysis or deficit?** ______________ |
| **Yes** | **No** | **Epilepsy or Seizures** |
| **Yes** | **No** | **Cancer (type/treatment)** ________________________________ |
| **Yes** | **No** | **Lung Disease: Emphysema Asthma TB Valley Fever Pneumonia** |
| **Yes** | **No** | **Kidney Problems** |
| **Yes** | **No** | **GI Disorders: Diverticulosis Stomach Ulcers Ulcerative Colitis Crohn's Disease Irritable Bowel Disorder** |
| **Yes** | **No** | **Hepatitis – if yes, what type?** ___________________________________ |
| **Yes** | **No** | **Anemia or Blood Disorder** |
| **Yes** | **No** | **Phlebitis or Blood Clots** |
| **Yes** | **No** | **Thyroid Disease: Hyperthyroid Hypothyroid** |
| **Yes** | **No** | **Arthritis** |
| **Yes** | **No** | **Glaucoma Macular Degeneration Legally Blind** |
| **Yes** | **No** | **Mental Illness** |
| **Yes** | **No** | **Do you have a Pace Maker?** |

Other:______________________________________________________________________

Past Surgical History (please include dates): ___________________________________________

______________________________________________________________________

Have you ever had a blood transfusion? Yes No If Yes, Any Reactions? _______________________

Have you ever had general anesthesia? Yes No If Yes, Any Problems? _______________________

**PLEASE LIST ALL MEDICATIONS AND DOSAGES:** _________________________________

______________________________________________________________________

Please circle if you are taking any of the following: Coumadin Daily Aspirin Diabetes Medication

Are you allergic to any medications? Yes______No______If Yes, please list the medications and any type of reaction:

______________________________________________________________________

Social History: Do you smoke? Yes_____No_____If Yes, packs per day_____How many years_____If quit, when ___________

Alcohol Use: Yes______No______Drinks per__________day or week

Date of Last Chest X-Ray_______________Date of last EKG_______________Date of Last Mammogram _______________

## REVIEW OF SYSTEMS

PATIENT NAME____________________________ DATE_____________

**GENERAL:** DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? **(PLEASE CIRCLE)**

| | | | | |
|---|---|---|---|---|
| Fever | Sweat | Chills | Headaches | Dizzi |
| Weight gain or loss | Fatigu | Skin | Lymph node | |

Other: ______________________________________________________________

**HEART, LUNGS, VASCULAR:**

Coughing/wheezing Irregular heartbeat Chest tightness/pain Leg swelling
Coughing up blood Last Chest X-ray________Last EKG__________Leg ulcers
Other: ______________________________________________________________

**STOMACH DIGESTION:**

Changes in appetite Constipation/diarrhea Change in bowel habits Nausea/vomiting

Indigestion/heartburn Bloody/black stools Hemorrhoids Yellow color to skin/eyes Abdominal

bloating/swelling Bulges visible on the abdominal wall

Stomach pain that occurs after eating? If yes, what food types? ____________________
Last rectal exam ____________________
Have you ever had a lower bowel exam with a scope? If yes, when? _________________
Have you ever had an exam with a scope looking at the stomach? If yes, when? ____________________
Have you ever been to see a GI specialist? If yes, who? ______________________________________
Other: ______________________________________________________________

**KIDNEY,**

| | | | |
|---|---|---|---|
| Frequent urination | Urination at night | Pain with | Blood in |
| Hard to start/stop flow | Enlarged prostate | Impotence | |

Prostate cancer – if yes, what type of treatment? ______________________________________
Other: ______________________________________________________________

**FUNCTIONAL:**

Depression Anxiety Difficulty sleeping Under Psychiatric care
Other: ______________________________________________________________

**FEMALE MEDICAL HISTORY:**

Number of pregnancies________Number of children________Number of vaginal deliveries ________
C-sections YES/NO Are you currently pregnant? YES/NO Last menstrual period _____________ Are your periods painful? YES/NO
Do you have abnormal vaginal bleeding or discharge? YES/NO Do you currently have any palpable breast lumps? YES/NO
Do you have painful breasts? YES/NO if YES, is the pain related to your menstrual cycle? YES/NO
Do you have nipple discharge? YES/NO if YES, what color is the discharge?____________________ Do you have a family history of breast cancer? YES/NO

INVITAE

# Cancer family history questionnaire

| Patient name | Patient DOB (MM/DD/YYYY) | Age | Gender |
|---|---|---|---|
| Healthcare provider | | Today's date (MM/DD/YYYY) | |

## PERSONAL AND FAMILY HISTORY OF CANCER

Please include: yourself, parents, siblings, children, grandparents, grandchildren, aunts, uncles, nephews, nieces, half siblings, first cousins, great grandparents, and great grandchildren. Please be as thorough and accurate as possible.

☐ Adopted/unknown family history

| | 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 | 44 | — | — | Grandmother<br>Aunt | 47<br>51 | Cousin | 54 |
| ☐Y ☐N | BREAST CANCER | | | | | | | |
| ☐Y ☐N | OVARIAN CANCER (Peritoneal/fallopian tube) | | | | | | | |
| ☐Y ☐N | UTERINE/ENDOMETRIAL CANCER | | | | | | | |
| ☐Y ☐N | PROSTATE CANCER | | | | | | | |
| ☐Y ☐N | COLON/RECTAL CANCER | | | | | | | |
| ☐Y ☐N | PANCREATIC CANCER | | | | | | | |
| ☐Y ☐N | OTHER CANCER(S) (Specify cancer type) | | | | | | | |

☐Y ☐N Are you of Ashkenazi Jewish descent? *(Jewish with ancestors from Central or Eastern Europe)*

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please describe and include a copy of result if possible)*

## HEREDITARY CANCER FEATURES

Please complete this section with your healthcare provider

### YOUR PERSONAL HISTORY

#### HEREDITARY BREAST CANCER SYNDROMES*

- ☐ Breast cancer diagnosed at or before age 50
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple negative breast cancer diagnosed at or before age 60
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Metastatic or intraductal/cribriform prostate cancer
- ☐ Ashkenazi Jewish ancestry, regardless of personal history of cancer

#### HEREDITARY COLON CANCER SYNDROMES

- ☐ Colorectal cancer before age 50
- ☐ Endometrial/uterine cancer before age 50
- ☐ Tumor with mismatch repair (MMR) deficiency†
- ☐ Two or more Lynch syndrome cancers‡
- ☐ One Lynch syndrome cancer and one or more relatives with a Lynch syndrome cancer

* Including: Breast (female and male), ovarian, pancreatic, prostate cancer

† Via PCR, NGS, or IHC. Screening for MMR deficiency is recommended for all colorectal and endometrial cancer tumors and should be considered for other Lynch syndrome cancers.

‡ Including: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, and brain cancer, as well as sebaceous adenomas

### YOUR FAMILY HISTORY

#### HEREDITARY BREAST CANCER SYNDROMES

- ☐ Relative with breast cancer at or before age 50
- ☐ Male relative with breast cancer
- ☐ Relative with ovarian cancer
- ☐ Relative with pancreatic cancer
- ☐ Relative with metastatic or intraductal/cribriform prostate cancer
- ☐ Three or more relatives with breast and/or prostate cancer
- ☐ A previously identified pathogenic variant ("mutation") in the family
- ☐ Ashkenazi Jewish ancestry, regardless of family history of cancer

#### HEREDITARY COLON CANCER SYNDROMES

- ☐ At least one first-degree relative with colon or endometrial cancer before age 50
- ☐ At least one first-degree relative with more than one Lynch syndrome cancer
- ☐ Two or more relatives with a Lynch syndrome cancer,‡ at least one before age 50
- ☐ Three or more relatives with a Lynch syndrome cancer
- ☐ A previously identified pathogenic variant ("mutation") in the family

## CANCER RISK ASSESSMENT REVIEW

To be completed after discussion with healthcare provider

If any of the boxes above are checked, this history has features that may indicate a hereditary cancer syndrome and warrants consideration of genetic testing.

| Patient's signature | Date (MM/DD/YYYY) |
|---|---|
| Healthcare provider's signature | Date (MM/DD/YYYY) |

For office use only: Patient offered hereditary cancer genetic testing? ☐YES ☐NO | ☐ACCEPTED ☐DECLINED

Follow-up appointment scheduled: ☐YES ☐NO | Date of next appointment ____________

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## DUCHARME GENERAL FINANCIAL POLICY

**Thank you** for choosing Ducharme General Surgery, PLLC for your surgical needs. The physicians and staff are committed to providing you with the highest quality of care. This following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice. We ask that you please review and confirm with your signature below. All billing is completed as a courtesy to our patients on behalf of their health insurance provider. Patients are financial responsible for all medical services.

### INSURANCE

Although we are participants of many insurance companies, it is ultimately your responsibility to confirm that Ducharme General Surgery, PLLC or your individual doctor, is in fact a provider for your particular insurance. We will submit a claim for payment for your services to your insurance as a courtesy, but you are responsible for any copays or deductibles not covered by your insurance. These are collected at time of service. If you are billed for any balance, payment is required within 30 days of receipt of a bill. Secondary insurance claims are filed as a courtesy,and become the responsibility of the patient if payment is not received within 60 days of filing a claim. It is your responsibility to be aware of your benefits with your insurance. If your insurance information, copay, or coverage has changed at any time during your treatment, it is your responsibility to notify the office with the most current and up-to-date information.

### PATIENT RESPONSIBILITY

Copayments and deductibles are due prior to being seen. If you require a bill sent to you for your copay, a $10.00 processing fee will be added to your balance. It is your responsibility to provide us with any referral required from your insurance. Any service deemed "non-covered" by your insurance will be your responsibility. If you do not have insurance, or we are not contracted with your particular insurance, you will be required to pay for services prior to receiving them. "Self-pay" accounts are eligible for a discount, which is due prior to any services; NO payment arrangements are made when any discounts have been applied. If a circumstance arises where payment arrangements are approved, the discount will be taken after all payments are received. If you fail to adhere to your payment agreement, your full balance along with additional fees will be assigned to a collection agency. If your account is referred to a collection agency, you will be responsible for all costs. If you need to reschedule or cancel your office appointment please contact our office 24 hours prior to your appointment to avoid a $25.00 fee. All appointments that are rescheduled a third time will require a prepayment charge of $25.00 which, is not associated with your required copay.

### PAYMENT METHODS

For your convenience, acceptable forms of payments are; cash, check, money order, VISA, MasterCard, American Express, or Debit cards. Please note: if a personal check is returned for insufficient funds, there will be a $25.00 fee added to your account.

### BILLING INQUIRIES

If you have any questions regarding a bill you received from our office, please feel free to contact our Business Office at (520) 722-3777. Our office hours are 8:00am – 5:00pm.

Thank you for allowing Ducharme General Surgery, PLLC to be an important part of your medical care. For any further questions or concerns our staff is available to assist you.

### ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, and understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to Ducharme General Surgery, PLLC.

**Signature**____________________________________ **Date** __________________

**1200 N El Dorado Pl, STE I-910 Tucson AZ 85715. Phone (520) 526-2325. Fax (520) 526 2837**

## DUCHARME GENERAL SURGERY, PLLC
## Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave a detailed telephone message (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system or with a trusted family member. It should be noted that our current notice of privacy practices does allow us to call you with courtesy reminder regarding any upcoming appoints(s)/ Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab and test results and with whom we may leave it.

PLEASE CHOOSE ONE OF THE FOLLOWING:

I DO CONENT for DUCHARME GENERAL SURGERY, PLLC and her staff to leave detailed messages:

I, ______________________________ give DUCHARME GENERAL SURGERY, PLLC permission to leave telephone messages regarding my medical care with the following options: (initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

Answering machine______________________________ Initial ________
My cell phone ______________________________ Initial ________
Spouse (Name) ______________________ ________ Initial ________
Other (Name and phone #) ______________________ Initial ________
Other (Name and phone #) ______________________ Initial ________

Signature ________________________________ Date ____________

I DO NOT CONSENT to leave detailed messages on my phone or answering machine or with any member of my family.

REVOCATION OF PRIOR CONSENT: I wish to rescind or stop the above authorizations.

Signature ________________________________ Date ____________