BURTON S. BRODSKY, M.D., P.L.C.
PATIENT INFORMATION – PRE-VISIT

TODAYS DATE: APPOINTMENT DATE:

PATIENT INFORMATION

PATIENT'S NAME:____

ADDRESS:______________________________ CITY:___________________STATE:_______ ZIP:____________

HOME PHONE: (___)-_____-_____ BUSINESS PHONE: (___)-_____-_____ CAR PHONE: (___)-_____-_____

SOCIAL SECURITY NUMBER _____-_____-_____ BIRTH DATE___/___/_____ AGE____

MARRIED___WIDOWED___SINGLE___DIVORCED___ (CHECK ONE)

EMPLOYER:_____________________________________ OCCUPATION_______________________________

ADDRESS:______________________________ CITY:___________________ STATE:_______ ZIP: ___________

REFERRING PHYSICIAN:___________________ REFERRING RELATIVE OR FRIEND__________________

EMERGENCY CONTACT NAME: ________________ EMERGANCY CONTACT PHONE (___)-_____-_____

SPOUSE / GUARDIAN INFORMATION

SPOUSE'S NAME:_________________________GUARDIANS NAME (IF MINOR)______________________

EMPLOYER:________________________________ OCCUPATION:__________________________________

ADDRESS:______________________________ CITY:___________________ STATE:_______ ZIP: ___________

BUSINESS PHONE (___)-_____-_____ SOCIAL SECURITY NUMBER _____-_____-_____

MEDICAL INFORMATION

NATURE OF CURRENT PROBLEM:____

DRUG ALLERGIES:____

LAST MENSTRUAL PERIOD:____________________________

INSURANCE INFORMATION

BLUE CROSS/BLUE SHIELD SUBSCRIBER:_____________________________ BIRTHDATE___/___/_____
GROUP NUMBERS_______________ EFFECTIVE DATE_______________
SERVICE CODES____
CONTRACT NUMBERS____

MEDICARE NUMBERS___________________ SUBSCRIBER_______________________________________

PRIVATE INSURANCE COMPANY________________________ POLICY NUMBERS____________________
SUBSCRIBERS NAME____ SUBSCRIBERS SSN ____-____-_____

INSURANCE ADDRESS: ___________________________________
____

PHONE NUMBER: (___)-_____-______

BURTON S. BRODSKY, M.D., P.L.C.
911 EAST NINE MILE ROAD
FERNDALE, MICHIGAN 48220

TELEPHONE (248) 543-2229
FAX (248) 543-7878

To All of Our Patients:

Due to continuous changes of insurance benefits, we are unable to maintain current coverage information on every patient's policy. It is therefore necessary that the subscriber/patient be aware of their benefits, such as

HOSPITAL PRECERTIFICATION

PRIOR AUTHORIATIONS

SECOND OPINIONS

COST SHARING PROGRAMS (DEDUCTAIBLE / COPAYS)

LABORATORY COVERAGE

IMPORTANT: REGARDING PROCESSING OF LABORATORY TESTS

You must also be aware of what laboratory your tests are sent to. All blood test, cultures and smears prepared in our office are sent to **Beaumont Reference Laboratory** for reading the cultures, smears and blood testing. The patient is responsible for all cost incurred by the lab.

These test are not included in the physician's fee for the exam that you receive.

Thank you for your cooperation

_______________________________________ ________________

Signature **Date**

____

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DEAR PATIENT:

ALL OF OUR PATIENT'S BILLING IS DONE THROUGH A COMPUTER SYSTEM. TO FACILITATE OUR BILLING PROCESS, IN TERMS OF THE DOCTOR RECEIVING PAYMENT, OR YOU BEING REIMBURSED, WE NEED A SIGNATURE ON FILE AND A RELEASE OF MEDICAL INFORMATION.

PLEASE SIGN BELOW. THIS FORM WILL BE KEPT IN YOUR MEDICAL CHART. THANK YOU FOR YOUR COPPERATION.

1. SIGNATURE OF PATIENT OR AUTHORIZED PERSON. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS BILLING CLAIMS AND REQUEST BENEFITS EITHER TO MYSELF OR THE PARTY THAT ACCEPTS ASSIGNMENT OR PARTICIPATION.

X____ DATE:____________________

2. I AUTHORIZE PAYMENT TO MY PHYSICIAN FOR SEVICES RENDERED TO HIM/HER. I ALSO WILL BE RESPONSIBLE FOR ANY CO-PAYS AND/OR DEDUCTIBLES REQUIRED BY MY PARTICULAR INSURANCE PLAN.

X____ DATE:____________________

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that **Burton S. Brodsky, M.D.** Notice of Privacy Practices prior to signing this document. **Burton S. Brodsky, M.D.** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **Burton S. Brodsky, M.D.** The Notice of Privacy Practices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **Burton S. Brodsky, M.D.** duties with respect to my protected heath information.

Burton S. Brodsky, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of **Burton S. Brodsky, M.D.** and request a revised copy to be sent in the mail or asking for one at the time of my next appointment.

____ ____________

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representatives Authority

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ____________________ Physician: ___________________
Date of Birth: ____________________ Date Completed: ______________

Instructions: Please circle (Y) to those that apply to You and/or Your Family (on both your mother's or father's side). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes, if you circle (Y) to any statement below, you May be appropriate for genetic testing. Ask your healthcare provider for addition information.

BREAST AND OVARIAN CANCER

	Relationship	Age at Diagnosis
Y N Breast cancer before age 50	________________________	_______________
Y N Ovarian cancer	________________________	_______________
Y N Breast cancer in both breast or Multiple primary breast cancer	________________________	_______________
Y N Both breast and ovarian cancer (In an individual or a family)	________________________	_______________
Y N Male breast cancer	________________________	_______________
Y N 2 or more breast or ovarian cancer (in an individual or a family)	________________________	_______________
Y N Ashkenazi Jewish ancestry & personal Or family history of breast or ovarian Cancer	______________________	_______________

COLON AND UTERINE CANCER

	Relationship	Age at Diagnosis
Y N Uterine cancer before age 50	________________________	________________
Y N Colorectal cancer before age 50	________________________	________________
Y N Both uterine & colorectal cancer (in an individual or a family)	________________________	________________
Y N 2 or more uterine or colorectal cancer (in an individual or a family)	_______________________	________________
Y N Uterine and /or colorectal cancer and Ovarian, stomach, kidney/urinary Tract, brain or small bowel cancer (in an individual or family)	_______________________	________________
Y N 10 or more colon polyps found in A lifetime	________________________	_______________

( ) Candidate for further risk assessment and/or genetic testing
( ) Information given to patient to review
( ) Patient offered genetic testing
( ) Accepted ( ) Declined

Patient Signature______________________ Physician Signature ______________________