



Clinical Genetics Service Helping You and Your Family Reduce Your Risk

Aaron G. Margulies MD

Compassionate surgical
care you can trust

Your appointment is _____ at _____AM/PM

<u>North Office Location</u>	<u>West Office Location</u>	<u>Jefferson City Location</u>	<u>Newport Location</u>
7714 Conner Road Suite 107 Knoxville, TN 37849	Tennova Turkey Creek Medical Center 10810 Parkside Drive Suite G-11 Knoxville, TN 37934	Jefferson Memorial 120 Hopsital Drive Suite G-50 Jefferson City, TN 37760	Newport Medical 434 Fourth Street Suite 301 Newport, TN 37821

Dear _____,

Thank you for your interest in the Clinical Genetics Service. I look forward to working with you to evaluate your risk for breast cancer and/or hereditary cancers and to develop approaches to reduce your risks for cancer. Our service also includes risk assessment for those with breast cancer, ovarian cancer, colorectal cancer, uterine cancer, and other cancers to assess the role genetics may play in cancer development.

In an effort to expedite your visit, please complete the attached questionnaire packet and bring it to your appointment. In addition, if you or anyone in your family has already pursued hereditary cancer genetic testing, it is very important that you bring a copy of the test result to your appointment, if possible. If appointment not scheduled above, I will contact you to schedule an appointment convenient for you.

During your visit, we will review your personal and family history and your lifestyle questionnaire to assess whether a hereditary cancer syndrome may explain some of the cancers in your family. We will discuss the basic genetics of hereditary breast and ovarian cancer syndrome (HBOC), Lynch syndrome, and other cancer syndromes as appropriate and discuss strategies for an individualized healthcare plan for cancer risk reduction. If genetic testing is indicated, then testing can be initiated at the end of the appointment via a blood sample. Insurance coverage and the testing laboratory's pre-authorization process will be discussed at your appointment.

Early Detection and Risk Reduction are our Key Goals in the Clinical Genetics Service.

If your insurance requires a referral from your primary care physician, then please ensure that a referral is completed prior to scheduling your appointment. All other charges will be filed with your insurance.

****If Imelda has emailed you a link to a family pedigree website, CRA Health, then please complete the online questionnaire two days before your scheduled appointment. ****

If you have any questions or need further assistance, please give me a call at **865-692-1602**.
I look forward to meeting with you soon.

Sincerely,

Imelda G. Margulies, MSN, FNP- BC
Director, Clinical Genetics Service

Email: ImeldaFNP@AaronMD.com

FAX: (865) 692-1619

Websites to View: www.aaronmd.com; www.mysupport360.com; www.ambrygen.com/patient

Patient Demographic & Consent Form

First Name: _____ Middle Initial _____ Last Name: _____

DOB: ____/____/____ SS#: ____-____-____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Numbers

Home: (____) _____

Mobile: (____) _____

Work: (____) _____

Occupation: _____

Preferred Method of Contact: (Circle One)

Home Mobile Work E-Mail

Marital Status: _____

Email: _____@_____

Employer: _____

Emergency Contacts

1. _____ Relation: _____ Phone: _____

2. _____ Relation: _____ Phone: _____

Do you consent for our office to leave a voice message if needed? **Yes No**

May we contact and share medical information with your emergency contacts if needed? **Yes No**

Would you like an email for sign-up information to Dr. Margulies' blog on Breast Cancer? **Yes No**

Would you like an email invite to register an account on our patient portal? **Yes No**

Which Office is most convenient for you? (Circle One) **Powell Turkey Creek Jefferson City Newport**

How did you hear about our practice? _____

If you are a **Breast Care Patient**, do you give consent for Dr. Margulies to discuss your case with other physicians? **Yes No**

If you are a **Genetics Patient**, do you give consent for our office to release or obtain copies of your genetic testing? **Yes No**

Insurance *If your insurance carrier through your spouse or someone else please complete the following:

Name of Insured: _____ DOB: _____ SS#: ____-____-____

Treating Physicians: Primary Care Physician: _____ Referring Physician: _____

Medical Oncologist: _____ Radiation Oncologist: _____

Gynecologists: _____

Pharmacy: Name: _____ City: _____ Phone: _____

By signing below, I verify that all the information above is correct. I also verify that I have been offered and have reviewed a copy of the Patient Privacy Notice required by HIPAA and understand my right to privacy as a medical patient of Aaron G. Margulies MD, PLLC.

Patient / Responsible Party Signature: _____ Date: _____

Name: _____ DOB: _____ MRN: _____

How many sisters do you have? _____ How many brothers? _____

How many children do you have? _____ Daughters _____ Sons _____

How many sisters does your mother have? _____ How many brothers? _____

How many sisters does your father have? _____ How many brothers? _____

Ethnic background: _____ Ashkenazi Jewish? Y/N

***PLEASE LIST ALL MEMBERS OF YOUR FAMILY ALIVE OR DECEASED (REGARDLESS OF CANCER)**

***Indicate who (including yourself) has had Cancer - (Especially breast, ovarian, pancreatic, prostate)**

RELATIVE	First Name	Alive (Age)	Deceased (Age)	Cancer – Y/N	Type	AGE at DIAGNOSIS
You						
Daughter						
Daughter						
Son						
Son						
Your Family						
Sister						
Sister						
Brother						
Brother						
Mother						
Father						
Mother's Side						
Grandmother						
Grandfather						
Aunt						
Aunt						
Uncle						
Uncle						
Father's Side						
Grandmother						
Grandfather						
Aunt						
Aunt						
Uncle						
Uncle						

****If you have a large family history of cancer, please list on the back of this sheet additional family members (cousins, etc.) that may provide more accurate information regarding your family history of cancer.**

Hereditary Cancer Genetics Questionnaire		Clinical Genetics Service	
Name: _____		DOB: _____	
Reason for Visit: (give a brief description):			
Date of Last Breast Imaging: _____		Location: _____	
Do you have dense breast tissue? YES / NO			
Medical History / Past Surgeries / Past Breast Surgeries			
Have you ever had a colonoscopy? YES / NO		If yes, Age of most recent colonoscopy? _____	
Colon Polyps: YES / NO		If yes, Number of polyps? _____	
Previous History of any Breast Biopsies: YES / NO		If yes, how many biopsies have you had? _____	
If yes, have you ever had Atypia, ADH, or LCIS? _____			
Medication Allergies:			
<input type="checkbox"/> NKDA			
Daily Medications & Supplements:			
Regular Aspirin Usage: YES / NO		Regular Ibuprofen Usage: YES / NO	
Social History & Risk Calculations			
Employment Status: Employed Retired Disabled		Occupation (if employed): _____	
Marital Status: _____		Education: _____	
Ashkenazi Jewish Heritage?		YES	NO
Hispanic?		YES	NO
Tobacco Use: CURRENTLY IN THE PAST NEVER		Number of years used? _____	
If yes, what type do you use? _____		If currently using, how much per day? _____	
Alcohol Use: YES NO		If YES, number of drinks per week? _____	
Exposures to Hazardous Materials: Asbestos Benzene Lead Radiation Sunburn Other: _____			
Vegetables: _____		Number of servings per day? _____	
Hours per week of vigorous exercise: _____			
Weight: _____		Height: _____	
Number of Pregnancies: _____		Number of Live Births: _____	
Age of First Menses: _____		Age of First Live Birth: _____	
Date of Last Menstrual Cycle: _____		Age Periods Stopped: _____	
Hysterectomy: YES / NO		If YES, at what age was this performed? _____	
Ovaries Present: YES / NO		If NO, at what age were they removed? _____	
Oral Contraceptive Use: YES / NO			
If YES, age when started: _____			
If YES, how many years used _____		If YES, when did you discontinue use? _____	
Hormone Replacement: <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST <input type="checkbox"/> NEVER			
(If yes, what type of hormone? <input type="checkbox"/> Estrogen only <input type="checkbox"/> Progesterone only <input type="checkbox"/> Estrogen & Progesterone			
If YES, how many years used _____		If YES, when did you discontinue use? _____	
Have you had cancer genetic testing? YES / NO		Description: _____	
Has cancer genetic testing been done in the family? YES / NO		Description: _____	



Aaron G. Margulies, MD, PLLC

Aaron G. Margulies, MD, FACS

Imelda Margulies, MSN, FNP-BC

FINANCIAL RESPONSIBILITY FORM

At the office of **Aaron G. Margulies, MD, PLLC**, we strive to give you the best possible care. In order to serve this purpose, it is important that our patients understand the process of reimbursement. Please read this Financial Responsibility Form and sign to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier.

We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payment due will be yours.

***If you have any changes in your insurance coverage you must notify us prior to your appointment.**

DEDUCTIBLES, COINSURANCE AND COPAYMENTS

The deductible is determined by your individual contract with your insurance carrier. You are responsible for your deductibles, copayments, and coinsurance. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay deductibles, coinsurance and copayments, when this applies.

NON-COVERED SERVICES AND MEDICAL NECESSITY

All patients are responsible for account balances if their insurance carrier denies payment for services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary.” To avoid this, please check with your insurance carrier prior to receiving any treatment or services.

By signing below, I authorize the release of any medical information necessary to process insurance claims filed to my insurance carrier on my behalf or on the behalf of my dependents. I authorize payment for medical benefits to be made directly to my physician for services rendered at the office of **Aaron G. Margulies, MD, PLLC**.

I certify that I have read the above disclosure statements, understand my responsibilities, and agree to the terms written above.

Patient / Responsible Party Signature _____ **Date** _____

Patient / Responsible Party Name (Please Print) _____

Relation to Patient: _____