LINDA I. SODOMA, D.O.

MEDICAL HISTORY FORM

NAME_____ DOB_____

DATE_____ SSN_____

I. What brings you to see the Doctor?_____

_____

_____

II. **Menstrual History**: First date of last menstrual period_____
Age when 1st period started_____ Age at menopause_____ Hysterectomy **Yes No**
Are your cycles regular? **Yes No** Are your periods: **Regular Irregular**
How many days do you bleed?_____ How long are your cycles (average is 28-30 days)_____
How many days of heavy flow?_____ Do you need double protection? **Yes No**
Do you have bleeding between periods? **Yes No** Are your periods painful? **Yes No**
How many days of pain per cycle?_____

III. **Obstetrical History**: Total number of pregnancies_____ Miscarriages_____
Elective terminations_____ Living Children_____

YEAR	MONTHS PREGNANT	COMPLICATIONS	BIRTH WEIGHT	SEX	COMMENTS

IV. **Gynecologic History**
Date of last pap smear_____ Have you ever had an abnormal pap? **Yes No**
Have you ever had an infection of your uterus, tubes, or ovaries (PID)? **Yes No**
Prior Gynecological surgeries_____

_____

_____

Have you ever had Chlamydia, gonorrhea, herpes, genital warts or any other sexually transmitted disease? **Yes No** Do you have frequent vaginal infections/abnormal discharge? **Yes No**
Are you sexually active? **Yes No** Do you have more than one sexual partner? **Yes No**
Do you have pain or bleeding with intercourse? **Yes No**
When was your last Mammogram?_____ Was it normal? **Yes No**
Any other significant past gynecological history?_____

_____

_____

V. **Contraception**: Current Method (circle):

None Condoms Tubal Ligation Pills IUD NuvaRing ESSURE

Rhythm Vasectomy Diaphragm Withdrawal Foam Other_____

VI. **Family History**

RELATIONSHIP	AGE OR AGE AT DEATH	ILLNESS OR CAUSE OF DEATH
MOTHER		
FATHER		
SISTER		
BROTHER		

Any family history of (circle all that apply) **Diabetes** **Heart Disease** **High Cholesterol** **Alzheimer's**
Strokes **Breast Cancer** **Uterine Cancer** **Ovarian Cancer** **Other Cancers** **Osteoporosis**

VII. General Medical History

Do you have any ongoing medical problems?_____

_____

Prior Non-gynecological surgeries?_____

_____

List current medications_____

_____

List vitamins and herbal supplements including doses_____

_____

Allergies to medications and reaction_____

_____

Allergies to food and reaction_____

Allergies to the environment and reaction_____

List childhood illnesses_____

_____

Has your weight changed in the last year? **Yes** **No** If yes, how much?_____

Do you have problems with the following?

Head, eyes, ears, nose & throat (convulsions, visual difficulty, seizures, etc)	YES	NO
Breathing (cough, asthma, TB, valley fever)	YES	NO
Hypertension	YES	NO
Diabetes	YES	NO
Heart Disease (heart attack, palpitations, chest pain, murmur)	YES	NO
Breast Discharge (milky, watery, bloody), Pain, or Breast Lumps	YES	NO
Nausea, Vomiting, Diarrhea, Blood in Stool, Hepatitis	YES	NO
Kidney or Bladder Infection, Stones, Blood in Urine	YES	NO
Skin Problems (including excessive hair, hair loss, acne)	YES	NO
Emotional Problem (depression, suicide attempts, anxiety)	YES	NO

Please explain any *Yes* answer_____

_____

_____

VIII. Social History

Do you smoke? **Yes** **No** If so, how long have your smoked?_____Years Cigarettes/Day_____
Did you smoke previously?_____Years When did you quit?_____
Do you drink alcohol? **Yes** **No** What and how much?_____
Do you use street drugs? **Yes** **No** Identify drugs_____
Do you exercise? **Yes** **No** What type and how often?_____
Do you eat a balanced diet? **Yes** **No**
Occupation_____

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 Aunt	47 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

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

* 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

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 _____

DR. LINDA SODOMA, DO
Patient Registration Form

Revised July 2021

PERSONAL INFORMATION

PATIENT NAME: _____ DOB: _____/_____/_____ GENDER: M F

SSN: _____ MARITAL STATUS: _____ **LEFT** OR **RIGHT** HANDED?

MAILING ADDRESS: _____ CITY, STATE ZIP: _____

CIRCLE ONE: YEAR ROUND RESIDENT or SEASONAL RESIDENT

ALTERNATE/SEASONAL ADDRESS: _____ CITY, STATE ZIP: _____

CELL PHONE: _____ HOME PHONE: _____ E-MAIL ADDRESS: _____

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE: _____

MISC. INFORMATION

EMERGENCY CONTACT NAME: _____ RELATIONSHIP TO YOU: _____

PHONE#: _____ MAY S/HE MAKE MEDICAL DECISIONS FOR YOU? YES NO

PREFERRED PHARMACY & CROSS STREETS: _____

PRIMARY CARE PHYSICIAN NAME & PHONE _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? FRIEND INTERNEST SEARCH PCP REFERRAL INSURANCE REFERRAL

REFERRING PHYSICIAN NAME: _____ PHONE#/ADDRESS: _____

INSURANCE INFORAMTION

PRIMARY INSURANCE

INSURANCE CO. _____

CLAIMS ADDRESS _____

POLICY/MEMBER # _____

GROUP # _____

PRIMARY INSURED'S NAME _____

REALATIONSHIP TO INSURED _____

INSURED'S GENDER: M F DOB_____/_____/_____

SPECIALIST CO-PAY $_____

SECONDARY INSURANCE

INSURANCE CO. _____

CLAIMS ADDRESS _____

POLICY/MEMBER # _____

GROUP # _____

PRIMARY INSURED'S NAME _____

REALATIONSHIP TO INSURED _____

INSURED'S GENDER: M F DOB_____/_____/_____

SPECIALIST CO-PAY $_____

Assignment and Release: 1. I hereby assign my insurance benefits to be paid directly to the physician; or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make out the check to me and the rendering physician. 2. I also authorize the physician to deposit checks received on the patient's account when made out to the patient. 3. I also authorize the physician to release any information required to process claims or required in the course of my exam and treatment. 4. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. 5. I authorize my rendering physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Patient Signature *or* legally authorized individual Date

_____ _____

Printed Name if signed on behalf of the patient Relationship to Patient

LINDA I. SODOMA DO
4001 E BASELINE ROAD, STE 208 GILBERT AZ 85234
PHONE: 480-668-4411 FAX 480-776-5169 WWW.LIFECAREFORWOMEN.COM

FINANCIAL POLICIES, NO SHOW POLICY AND PATIENT RESPONSIBILITIES

PLEASE READ THIS DOCUMENT COMPLETELY

SIGN AND DATE THIS PAGE TO CONFIRM YOU UNDERSTAND AND ACCEPT OUR POLICIES

The office of Dr. Linda Sodoma will bill your insurance as a courtesy. It is the responsibility of the patient to understand their insurance benefits, copays, deductibles and exclusions. Please make sure you understand your benefits completely.

— We expect your insurance to respond and pay claims in 90 days or less. Our contract with insurance companies
— requires that we file your insurance claim in a timely manner, and we expect claim consideration and reimbursement to follow similar criteria. We will advise you if your carrier fails to pay your claim in a timely manner.
— Reimbursement policies for gynecology services vary substantially. This depends upon the policy you and/or your employer have chosen. A call will be placed by this office in an effort to determine your benefits before treatment is rendered. NOTE: A quotation of benefits by your carrier is not a guarantee of payment. Insurance carriers will often quote a benefit and even authorize a procedure, but then not pay the claim for one of a number of reasons, including, but not limited to: pre-existing condition clauses, assignment of deductible, policy maximum, and coordination of benefits.
— You are required to notify this office of changes in your insurance status immediately. If your employment changes, so does your insurance. Insurance carriers have filing deadlines that must be met based on the date of service. Your failure to provide accurate, current information decreases the likelihood that your carrier will pay the claim and you will be responsible for those charges.
— There will be a $25 assessment for all returned checks. You will have to pay this charge before future appointments can be scheduled.
— Secondary claims are not filed automatically. We will file secondary claims upon your request for coinsurance and deductibles only. We will not file secondary carriers for copays.
— If you have an interruption of coverage during the course of obstetric care for any reason, this will mean that your
— care will have to be billed fee for service (itemized).This may result in higher coinsurance and deductible costs for you.
— All copays, deductibles and coinsurance are due at the time of service. This office accepts cash, checks, debit cards, Mastercard, Visa, AMEX and Discover credit cards. If you do not have your copay, your appointment may be rescheduled.
— Patient understands that there will be a $20.00 fee assessed for the completion of any insurance documentation, short term or long term disability forms, FMLA forms, leave of absence forms, or any other form of this nature.
— Patient will be advised that it will take 7 - 10 business days to complete these forms, and should prepare for this interval when making requests.
— Medical record requests can take up to 10 days to process, and records will not be available to a patient the same day that the patient makes the request. The physician must review the chart before records can be copied and sent out.
— Patient / guardian grants authority to Linda I. Sodoma DO PLC to deposit check payments issued by the insurer in two party format.
— Patient understands that Dr. Sodoma operates in good faith that the patient and the insurance company will reimburse the doctor for her time and care. In the event your insurance is terminated or fails to pay for office visits, procedures, injections, and/or hospitalizations, responsibility to pay the accrued debt resides with the patient.
— Failure to pay coinsurance, copayments, deductible assignments, and/ or non-covered services will result in the assignment of the delinquent debt to a collection agency. The patient will be responsible for any and all charges associated with the collection of the debt.
— Patient will check in no less than 10 minutes before the scheduled appointment time. If you are unable to keep your appointment, or will be late, please call the office to reschedule 24 hours prior to your scheduled appointment. A No-Show charge will be assessed if a call is not received 24 hours in advance of cancellations. Emergencies will be considered individually.

I understand and have had my questions answered regarding these policies and responsibilities. I acknowledge and agree that I am responsible for any and all portion of my bill not paid by insurance.

_____ _____
Patient / Guardian Signature Date

_____ _____
Office Representative Signature Date

LINDA I. SODOMA, DO
4001 E. BASELINE RD
SUITE 208
GILBERT, AZ 85234

Client/Patient Confidentiality

I give my consent for my physician to view and maintain a copy of my *Sure Scripts* prescription history as part of my clinical medical record. I understand that this information will remain confidential and will not be transferred to outside entities without my written consent.

I also have received and understand the policies outlined in the HIPAA summary "Notice of Privacy Practices".

_____ _____

Patient Signature **Date**

Coordination of Benefits

I am insured with _____
(Insurance company name)

☐ I do **not** carry a secondary insurance.

☐ I **do** carry secondary insurance with _____
(Insurance company name)

_____ _____

Patient Signature *or* legally authorized individual **Date**

_____ _____

Printed Name if signed on behalf of the patient Relationship to Patient

HIPAA FORM

Request for Disclosure or Restriction of Health Information

Linda I. Sodoma DO, PLC

Patient Name: _____ Date of Birth: _____

Previous Name: _____

DISCLOSURE

I give permission for _____ to *inquire about* and
Name and Relationship

receive information pertaining to my Protected Health Information (PHI) on my behalf.

This consent shall remain in effect until _____ **or until revoked**
Date

OR

RESTRICTION

I request that this office restrict the disclosure or use of my Protected Health Information (PHI) to *certain individuals* or for certain purposes as described below:

_____

_____

_____

_____ _____
Patient Signature *or* legally authorized individual Date

_____ _____
Printed Name if signed on behalf of the patient Relationship to Patient