Hetal Gor MD, FACOG

Women's Own OB/GYN LLC.
Board Certified Obstetrician & Gynecologist
180 Grand Avenue, Englewood, NJ 07631
Phone: 201-541-6868 Fax: 201-541-6869
hgormd@gmail.com

Date: _____ Home Phone: (____) _____ Cell Phone: (____) _____ Pharmacy # (____) _____

PATIENT INFORMATION (Please Print Clearly)

Name _____ SS/HIC/Patient ID# _____
Last Name First Name Middle Name
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐Married ☐Widowed ☐Single ☐Minor
☐Separated ☐Divorced ☐Partnered for ____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (___) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (___) _____

PRIMARY INSURANCE (Please Print Clearly)

Person Responsible for Account _____
Last Name First Name Middle Name
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address(if different from patient's) _____ Phone (___) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber# _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE (Please Print Clearly)

Is patient covered by additional Insurance? ☐ Yes ☐ No
Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address(if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (____) _____
Contract # _____ Group # _____ Subscriber# _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE (Please Print Clearly)

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr.Gor all insurance benefits for
Name of Insurance Company(ies)
services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my private health information and may disclose all information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.This consent will end one year from the date signed below. I certify that the above information is true and accurate as best to my knowledge. I acknowledge I am responsible for payment if my insurance company(ies) denies my claim. I am aware that for OUT OF NETWORK health insurances I am responsible for all cost that are not covered by my insurance. I have chosen to see Dr. Gor instead of an in network provider. I accept these terms and agree with my signature below. I'M ACCEPTING PRIMARY FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. WE WILL SEND YOU A BILL FOR THE AMOUNT YOUR INSURANCE COMPANY DETERMINES YOU OWE. OUR OFFICE UTILIZES COLLECTION AGENCIES TO FURTHER COLLECT ON UNPAID BALANCES **OVER 90 DAYS PAST DUE. YOU WILL BE RESPONSIBLE FOR COLLECTION FEES, LEGAL FEES, AND INTEREST OF 1.5%.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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ASSIGNMENT AND RELEASE (Please Print Clearly)

I _____ certify that I, and/or my dependent(s), have insurance coverage with
Patient Name
_____and assign directly to Dr.Gor all insurance benefits for services rendered , I understand that I am financially
Name of Insurance Company(ies)
responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my private health information and may disclose all information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.This consent will end one year from the date signed below. I acknowledge that all my contact information is accurate and up to date. I certify that the above information is true and accurate as best to my knowledge. I acknowledge I am responsible for payment if my insurance company(ies) denies my claim. I am aware that for OUT OF NETWORK health insurances I am responsible for all cost that are not covered by my insurance. I have chosen to see Dr. Gor instead of an in network provider. I accept these terms and agree with my signature below. I'M ACCEPTING PRIMARY FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. WE WILL SEND YOU A BILL FOR THE AMOUNT YOUR INSURANCE COMPANY DETERMINES YOU OWE. OUR OFFICE UTILIZES COLLECTION AGENCIES TO FURTHER COLLECT ON UNPAID BALANCES **OVER 90 DAYS PAST DUE.. YOU WILL BE RESPONSIBLE FOR COLLECTION FEES, LEGAL FEES, AND INTEREST OF 1.5%**

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ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and facilities listed in the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request separate written explanations of special privacy protections that apply to HIV related information and mental health information.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Representative

_____

Date

Doctor you can Trust

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OFFICE POLICY

In order to accommodate the needs and requests of my patient, I have enrolled in numerous programs.

While I am pleased to be able to provide this service to you, it is extremely difficult for my staff and I to keep up to date with all of the specific and various requirements of each and every plan, WITHOUT YOUR FULL COOPERATION. Please understand that each plan has different stipulations such as referrals, authorizations, lab work, etc. IT IS VERY IMPORTANT THAT YOU, THE PATIENT, COME TO OUR OFFICE WITH ALL OF THE REQUIRED DOCUMENTATION AND BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT, YOU, THE PATIENT ARE THE POLICY HOLDER AND IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN.

With your cooperation, I, your healthcare provider, can provide you with all the medical benefits to which you are entitled which is my primary concern.

***Please be advised any returned check will have a $25 administrative fee, bank fee, plus the amount of the check. Unfortunately, we will not be able to accept your checks anymore and will be accepted only cash.**

***BY SIGNING THIS POLICY I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED ABOVE. I'M ACCEPTING PRIMARY FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. WE WILL SEND YOU A BILL FOR THE AMOUNT YOUR INSURANCE COMPANY DETERMINES YOU OWE. OUR OFFICE UTILIZES COLLECTION AGENCIES TO FURTHER COLLECT ON UNPAID BALANCES **OVER 90 DAYS PAST DUE. YOU WILL BE RESPONSIBLE FOR COLLECTION FEES, LEGAL FEES, AND INTEREST OF 1.5%**

_____ _____

Signature Date

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____
Reason for Today's Visit: _____

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 *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, 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)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare 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: _____

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HEALTH HISTORY

Please fill out this confidential form so that Dr. H. Gor can best help you meet your entire well woman, gynecological, menopausal, pregnancy, and/or contraceptive needs.

Date ___ / ___ / _____
Name _____ Date of birth _____ Age _____
Occupation _____
Race / ethnicity _____ Birthplace _____
Education: _____
Emergency Contact _____

List all the medications, both prescription, over-the-counter, and/or herbal/nutritional supplements you are now taking regularly

_____
_____

Are you allergic to any medication, latex, food, or other substance? Yes / No
If yes, what? _____

What happens to you when you are exposed to this/these substance(s)? _____

MEDICAL HISTORY: If you have ever had or still have any of the following, please place a checkmark on the line to the *left side* if your answer is yes, and describe any positive any positive answers, including date of onset, treatment, etc., beside or below if additional space is required.

1. _____ High Blood Pressure
2. _____ Heart disease
3. _____ Heart murmur, or Mitral Valve Prolapse
4. _____ Stroke
5. _____ Phlebitis or clots in veins, or pulmonary embolism
6. _____ Diabetes
7. _____ Cancer (type)
8. _____ Asthma
9. _____ Lung disease
10. ____ Seasonal allergies
11. ____ Thyroid disorder
12. ____ Liver disease (including hepatitis)
13. ____ Anemia (low iron)
14. ____ Sickle Cell Anemia or Trait
15. ____ Blood or clotting disorders
16. ____ Hyperlipidemia (high cholesterol)
17. ____ Ulcer, gastrointestinal problems, or constipation/diarrhea (circle)
18. ____ Seizures
19. ____ Migraine headaches (with/without aura)
20. ____ Frequent headaches
21. ____ Frequent urinary tract infections
22. ____ Kidney disease
23. ____ Involuntary loss of urine or stool
24. ____ Muscle, bone, or joint problems
25. ____ Osteoporosis
26. ____ Under or overweight, or recent changes in weight
27. ____ Anorexia or bulimia
28. ____ Anxiety, depression, or other psychological/psychiatric problems
29. ____ Drug addiction, alcoholism, substance abuse
30. ____ Autoimmune disorders, Lupus
31. ____ Skin disorders
32. ____ Varicose veins
33. ____ Blood transfusions
34. ____ Glaucoma/eye or vision problems
35. ____ Corrective lenses/contacts
36. ____ Hearing loss
37. ____ Dental problems
38. ____ Blood transfusions
39. ____ HIV positive or AIDS
40. ____ Chicken Pox (varicella) disease or immunization
41. ____ German Measles (rubella) disease or immunization
42. ____ Rheumatic fever
43. ____ Date of last Tetanus shot _____
44. ____ Any other illnesses not specified above

_____

_____

_____

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SURGICAL HISTORY / HOSPITALIZATIONS

Please list the approximate date and type of any surgeries you have had:

_____

_____

Please list the date and type of any significant injuries, fractures, accidents, or hospitalizations you have had:

_____

_____

FAMILY HISTORY

Please check to the left and identify to the right, using the code key below, which family members have or had:
[M = mother, F = father, S = sibling, C = child, MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather, O = other]

1. _____ High Blood Pressure
2. _____ Cancer (type)
3. _____ Breast disease (or breast cancer)
4. _____ Heart disease
5. _____ Stroke
6. _____ Blood disorders (clotting problems,anemias, thalassemias)
7. _____ Phlebitis or blood clots in legs
8. _____ Diabetes
9. _____ Osteoporosis
10. _____ Hyperlipidemia (high cholesterol)
11. _____ Thyroid disease
12. _____ Seizures
13. _____ Kidney disease
14. _____ Lung disease, asthma
15. _____ Stomach, bowel, or gallbladder problems
16. _____ Depression
17. _____ Mental illness
18. _____ Alcoholism or substance abuse
19. _____ Mental retardation, Down's syndrome,or autism
20. _____ Congenital heart disease
21. _____ Cystic fibrosis
22. _____ Spina Bifida or neural tube defect
23. _____ Cleft lip/palate
24. _____ Other birth defects
25. _____ Sickle Cell Disease or Trait
26. _____ Tay Sachs, Canavans, or Gauchers disease
27. _____ Huntington's Chorea
28. _____ Muscular Dystrophy
29. _____ Other inherited genetic diseases
30. _____ Other, not specified above _____

_____

MENSTRUAL / GYNECOLOGICAL HISTORY

Last menstrual period began on _____ was this a normal period for you? _____
Age when had first period _____ How often do your periods occur? _____
How long does your bleeding usually last? _____ Are your periods: light, moderate, or heavy (circle)?
Do you spot or bleed between your periods? _____ Have you missed a period recently? _____
Have there been any changes in your periods over the last year? _____
Do you have premenstrual symptoms? _____ (cramping ____, bloating ____, irritability ____, weight gain ____, headache ____, breast tenderness ____, increased appetite ____, other _____)
If you are peri or postmenopausal, are you having associated symptoms, like hot flashes, night sweats, mood changes, insomnia, or painful intercourse? _____
Have you ever had a pelvic exam? _____ Have you ever had a bad experience with a pelvic exam? _____
Date of last Pap smear _____ Was most recent Pap smear normal? _____
Do you know how to do Self Breast Exams? _____ If yes, do you do them monthly? _____ What time of month? ____
Have you ever had a mammogram? _____ Date of last mammogram _____ Have any mammograms been abnormal? ___
Have you ever had a bone mineral density test (BMD, of DEXA scan)? _____ If yes, date _____
Did your mother ever take DES (diethylstilbestrol) when she was pregnant with you? _____

Have you ever had or do you still have:

1. _____ Any abnormal Pap Smears
2. _____ Pelvic infections, or pelvic Inflammatory disease
3. _____ Toxic Shock Syndrome
4. _____ Cervical, uterine, or ovarian cancer
5. _____ Uterine fibroids
6. _____ Uterine surgery(including Cesarean sections)
7. _____ Endometriosis
8. _____ Dysmenorrhea(severely painful periods)
9. _____ Infertility
10. _____ Abnormal or unusual vaginal bleeding
11. _____ Sexually Transmitted Infections (Herpes, Chlamydia, Gonorrhea, Trichomoniasis, HPV or warts, Syphilis, Hepatitis B, HIV) (circle)
12. _____ Frequent (>3/year) vaginal yeast infections
13. _____ Bacterial Vaginosis
14. _____ Unusual vaginal discharge(heavier than usual, foul, smelling, or itchy?)
15. _____ Breast lumps, cysts, discharge, breast cancer, or other breast disease

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SEXUAL HISTORY AND BIRTH CONTROL

Do you currently have a sexual partner (last 3 months)? _____ Have you ever been sexually active in the past? _____
Is your sexual partner male, female, or both? _____ # of sexual partners in last 6 months _____
Do any of your sexual partner(s) have any sexually transmittable infections (Herpes, Chlamydia, Gonorrhea, Trichomoniasis, HPV or warts, Syphilis, Hepatitis B or C, HIV)? _____ Do you have pain during or after sexual relations? _____ bleeding? _____ Are you having any sexual problems that you would like to discuss with Dr. Gor? _____
If you have a male sexual partner, are you currently using any birth control method? _____
If yes, which one(s) and for how long? _____
Does your male partner use condoms? _____ If yes, how often? _____
Are you satisfied with your present birth control method? _____
Do you want to start using birth control now, or try a new method? _____
Have you used other birth control methods in the past (yes/no), and have you had any problems or unintended pregnancies with prior birth control methods? _____ If yes, please list in order of use:

Method *Dates of Use* *Problems or comments*

_____
_____
_____

Is there violence in any of your relationships? _____
Have you ever been physically hurt by an intimate partner? _____
Are you afraid of a partner or other person in your life? _____
Have you ever been forced to have sex without your consent, or been sexually molested/assaulted/harassed, or been the victim of incest? _____
Have you ever had thoughts about suicide? _____ yes _____no

PREGNANCY HISTORY

Please detail your pregnancy/obstetrical history, including miscarriages, terminations, ectopics(tubal pregnancies), multiple births, full term births, preterm births, and stillbirths:

Date (m/yr)	# of weeks pregnant	Baby's Weight	Sex	Length of Labor	Mode of Delivery (vaginal, C-sec)	Anesthesia	Preterm Labor (Yes/No)	Place of Delivery	Complications (Prenatal, Postpartum, Postpartum Depression or Neonate	If live birth, is child still alive?

Do you plan to have children in the future? _____

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DIET, EXERCISE, AND SOCIAL HABITS

Do you smoke cigarettes or use other forms of tobacco? _____
If yes, how many a day _____ For how long _____ Are you interested in stopping? _____
Do you drink alcohol? _____ How many drinks daily? _____ Weekly? _____
Do you use marijuana, cocaine, ecstasy, heroin, or other drugs? _____ If yes, how frequently _____ Last used _____
Do you drink caffeinated beverages on a regular basis? _____ How many per day? _____

Do you have any dietary restrictions (vegetarian, wheat-free, lactose intolerant, etc.?) _____
_____

On average, how many servings per day do you have of:
Dairy products (milk, cheese, yogurt, ice cream, pudding) _____
Vegetables _____
Fruits _____
Breads, grains, or cereals _____
Protein foods (meat, poultry, pork, lamb, fish, eggs, tofu, nuts, cooked dry beans/peas): _____
Foods with Vitamin C (orange/grapefruit fruit or juice, tomatoes, peppers, cantaloupe, cabbage) _____
Foods with Vitamin A (yellow or orange colored fruits/vegetables) _____
# of glasses of water or non-caffeinated beverages _____
Desserts, sweets, "junk food" _____
Do you take folic acid supplements on a daily basis? _____

Do you exercise regularly? _____ How often? _____ What forms of exercise? _____
How many hours of sleep do you get, on average, per night? _____
Do you have a social support system (family, friends, etc) to which you can turn in times of stress/need? _____
Have you recently (last six months) traveled out of the country? _____ If yes, where? _____
Do you have any pets? _____ If yes, please specify _____
What do you do for fun? _____

AESTHETIC CONCERNS
Hair _____
Wrinkles _____
Weight _____
Vaginal _____
Health _____

Patient Signature _____

Date _____

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INTERNAL USE: PCID:_____Health Goal:_____

Identifying Your Wellness Care Plan

Name: _____ **Date:** _____ **Age:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email Address: _____ **Phone:** _____ **Date of Birth:** ____/____/____

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____
How many servings of vegetables do you consume per day? _____
How many servings of protein do you consume per day? _____
How many servings of bread/crackers/pasta do you consume daily? _____
Do you consume artificial sweeteners? ___ Yes ___ No If yes, what brands? _____
Do you consume fast food? ___ Yes ___ No If yes, what do you typically eat? _____
Do you eat breakfast? ___ Yes ___ No If no, what time is your first meal of the day? _____
Do you consume alcoholic beverages? ___ Yes ___ No If yes, how many per week? _____
Do you consume coffee? ___ No ___ Yes If yes, how many cups per day? _____
Do you consume dietary supplements? ___ No ___ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

_____ Lose weight _____ More energy _____ Sleep better _____ Improve digestion
_____ Improve blood work _____Prevent problems _____Anti-aging support _____Improve general health

If you could improve ONE thing about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1.What number best describes how you feel about your health today? _____
2.What health goal do you want to achieve? _____

Note: In our commitment to your health, our office provides our patients with access to a free online resource for education, science, and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

___ Health Reality Check ___ Genetics & Your Health ___ Why Diets Don't Work ___ Other: _____