Michele M. Hakakha, M.D., FACOG
9735 Wilshire Boulevard, Suite 207
Beverly Hills, CA 90212
310-274-2005

Date:_____

Patient: _____ Birthdate:_____

Married_____ Single_____Widowed_____ Divorced_____ Separated_____

Home Address:_____City:_____Zip_____

Home Phone_____Occupation_____

Social Security_____Driver's License_____

Patient Employed by_____Business phone_____

Business Address_____

Name of Spouse_____Occupation_____

Spouse Employed by_____Business Phone_____

Business Address_____

Patient referred by_____

If patient is a minor, name of responsible parent/guardian_____

Do you have medical or surgical insurance? Yes_____ No_____

Insurance Company_____

ID#_____ Group#_____

In order to minimize paper work, We **DO NOT BILL** our patients or their insurance companies. For your security, we don't keep credit cards on file. Please indicate how you intend to pay for this visit:

Cash____ Check____ Credit Cards_____

If you have health insurance, we will be glad to fill out the necessary claim form for you, but we **CANNOT** render services without receiving payment from you.

Patient Signature_____

Michele M. Hakakha, M.D., FACOG, Inc.

9735 Wilshire Boulevard, Suite 207

Beverly Hills, CA 90212

Tel: 310-274-2005

Fax: 310-274-2453

We would like to inform you of our CANCELLATION/NO SHOW policy effective November 1, 2006.

If you cancel an appointment without giving us 24 hours notice or do not show up for an appointment, you will be charged for the missed appointment.

For your convenience, we will call to remind you of your appointment 2 days in advance. If you are unable to keep your appointment, please call our office at least 24 hours prior. This will allow us to have appointment slots available for our patients with emergencies.

Thank you for your cooperation.

I have read and fully understand the above mentioned cancellation/no show policy.

_____ _____

Print Name Date

_____

Signature

Michele M. Hakakha, M.D., FACOG

9735 Wilshire Boulevard, Suite 207
Beverly Hills, CA 90212
Ph 310-274-2005

Email or text messages from Dr. Hakakha's office may contain information that I wish to keep private and confidential, including information about my healthcare treatment or diagnosis.

Email is not confidential and there is no way to assure the privacy of email on a shared computer or email account. Email communications travel across public internet. It is not possible to verify that email is actually received, opened and read by the addressee.

Dr. Hakakha and her staff take no responsibility for and disclaim any and all liability arising for any breach of confidentiality not caused by our office, inaccuracies or defects in software, communication lines, virtual private network, the internet or my internet service provider, access system, computer hardware or software, or any other service or device I use to access email or text messages.

Email and electronic messaging may not be monitored when we are out of the office. I understand that I need to follow up by telephone or in person if I have not received a response from Dr. Hakakha's office, or if 2 calendar days have passed and I have not received a response. I understand that I will not contact Dr. Hakakha's office using email or text if I have an emergent or urgent medical issue.

Dr. Hakakha and I hereby agree and consent to the use of email and texting to communicate with each other. There is a right to revoke this agreement in writing at any time. I authorize Dr. Hakakha and her staff to share confidential information with me about my healthcare treatment or diagnosis via email or texting.

All email and texting correspondence should be sent to the following email address/phone number:

Please print clearly the email address you wish to use: _____

Please print clearly the cell phone number you wish to use for texting: _____

Patient name: _____

Patient signature: _____ Date: _____

Name of physician: Dr. Michele Hakakha

Signature of Physician: _____

Michele M. Hakakha, M.D., FACOG, INC

9735 Wilshire Boulevard, Suite 207

Beverly Hills, CA 90212

Tel: 310-274-2005

Fax: 310-274-2453

To update our files with our new computer system, please provide us with the following :

Email Address: _____

Pharmacy name _____

Pharmacy address or street and city:

_____

_____

Pharmacy phone # _____

Allergies_____

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F):_____ **Today's Date(MM/DD/YY):**_____ **Health Care Provider:**_____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 or more people on the same side of my family (can include me) with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian (peritoneal/fallopian tube) cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	○ Y ○ N				
3 or more of these cancers on same side of my family at any age: **pancreatic, breast**, or **aggressive prostate*** *Gleason Score ≥7	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	○ Y ○ N				
Pancreatic cancer or aggressive prostate cancer and one relative with **breast cancer at age 50 or younger**	○ Y ○ N				
20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____	○ Y ○ N				
Colon/rectal or **Endometrial (uterine) cancer** before age 50	○ Y ○ N				
Personal history of **Endometrial (uterine) cancer** at any age‡	○ Y ○ N				
TWO individuals on the same side of my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○ Y ○ N				
THREE OR MORE individuals on the same side of my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colon/rectal or **endometrial (uterine) cancer**	○ Y ○ N				

‡ **PREMM$_{[1,2,6]}$ Score ≥ 5%**
* **Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).**

Have you or a family member had genetic testing for a **hereditary cancer syndrome**?	○ Y ○ N	If yes, Who?_____ What gene(s)?_____ What was the result? _____

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

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If YES, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com