Christine Chai, M.D.

1441 Avocado Ave, Suite 309
Newport Beach, CA 92660

Patient Information: **Birth Date:** ___________ **Age:**_________

Last Name: ____________________________ First:_______________________ Middle:________________

Address:______________________________ City: _________________ Zip Code:__________________

Telephone#:______________ Cell Phone#:_____________ Marital Status: M /D/S/ W

Email Address: ______________________ Preferred Pharmacy& Phone#________________

What telephone number may we leave private detailed messages? ______________________________

Referred By:

Employment Information:

Occupation: ____________________ Employed by:____

Address: ____ City: ____________ Zip Code: _______________

Tele hone#:

Emergency Contact Information:

Name: ____ Relationship: ___________________________

Address: City: _____________ Zip Code: _______________

Telephone#: Cell Phone#

Insurance Information:

Primary Insurance Carrier:

Address: ____ City: ___________ State: _Zip Code: _____________

Insured's Name: Birthdate: ________ Social Security #: _____________________

Relationship to Patient: Insured's Employer:_____________________________________

Insured's Group#: ID#: __________________ Policy#: _____________________

Effective Dates of Policy: From: To: ____________ Phone# _______________________

Secondary Insurance Carrier:

Address: ____ City: ___________ State: _Zip Code: ___________

Insured's Name: Birthdate: _________ Social Security#:___________________

Relationship to Patient: Insured's Employer: _____________________________________

Insured's Group#: ____________________ ID#: ___________________ Policy#: ____________________

Effective Dates of Policy: From: ___________ To: ____________ Phone# _______________________

Assignment of Benefits/Financial Agreement:

I hereby give authorization for payment of insurance benefits to be made directly to Christine Chai, M.D. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance company.(Medicare patients are subject to Medicare's policies and regulations.) I hereby authorize Christine Chai, M.D. to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:____ **Date:**___________________

Revised 4/5/23

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: ______________________ Date of Birth: ______________ Age: __________

Gender (M/F):________ Today's Date(MM/DD/YY):____________ Health Care Provider:________________

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

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

*Lynch Syndrome*** *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

*Lynch Syndrome*** *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

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

Patient's Signature:_______________________________ Date: ____________

Health Care 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:__________

HEALTH INTAKE FORM

Name____________________________________ **Today's Date**__________________

What brings you here today? ____

Primary Physician_________________________

CURRENT MEDICATIONS none ☐

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Do you take a multi-vitamin ☐ Omega 3/fish oil ☐ Aspirin ☐

Calcium ☐ Vitamin D ☐ Other vitamins or herbs ☐

ARE YOU ALLERGIC TO: No known drug allergy ☐

Penicillin	☐	Sulfa	☐	Codeine	☐
Latex	☐	Iodine	☐	Other	☐ ____________________

SURGICAL HISTORY:
Please indicate year when done

D and C	____________	Appendectomy	____________
Cesarean Section	____________	Gall Bladder	____________
Tubal Ligation	____________	Blood Transfusion	____________
Laparoscopy	____________	Breast surgery/ or biopsies	____________
Hysterectomy	____________		
Cryosurgery/laser	____________	Other surgeries	____________

MEDICAL HISTORY (check if yes)

No known medical problems ☐

Heart disease	☐	Autoimmune (lupus, MS,etc)	☐
Stroke	☐	Bleeding disorder/anemia	☐
Blood clots in legs/lungs	☐	Kidney disease/stones	☐
High cholesterol	☐	Bowel disease/IBS	☐
High blood pressure	☐	GERD	☐
Asthma	☐	Gallstones	☐
Lung/TB	☐	Hepatitis	☐
Diabetes	☐	Neurologic Issues	☐
Thyroid issues	☐	Migraine headaches	☐
Arthritis	☐	Depression/Anxiety	☐
Osteopenia/Osteoporosis	☐	Alcohol/Drug abuse	☐
Cancer (type) ____________	☐		

FAMILY HEALTH HISTORY (check if anyone in your family has ever had the following)

Heart disease/attack	☐	Thyroid disease	☐
Stroke	☐	Osteoporosis	☐
Blood clots in legs/lungs	☐	Alzheimer's/dementia	☐
High cholesterol	☐	Depression/schizophrenia	☐
Diabetes	☐	Alcoholism	☐

FAMILY CANCER HISTORY

Please check if there is a family history of any of the following cancers. If yes, then indicate family relationship (i.e. sister or paternal grandmother (PGM)) and age at diagnosis in the appropriate column.

Breast cancer	☐	________________
Ovarian cancer	☐	________________
Male breast cancer	☐	________________
Are you of Ashkenazi Jewish descent?	☐	________________
Uterine (endometrial) cancer	☐	________________
Colorectal cancer	☐	________________
Stomach, kidney/urinary tract, brain, or small bowel cancer	☐	________________
10 or more cumulative colon polyps	☐	________________
Melanoma	☐	________________
Pancreatic cancer	☐	________________
Other cancer	☐	________________

PREGNANCY HISTORY

Number of pregnancies _____ # of living children _____ # of deliveries _____
# of miscarriages _____ # of ectopics _____ # of abortions _____

GYNECOLOGIC HISTORY

Date of last Pap smear ______________ Normal? Yes ☐ No ☐
Date of last mammogram ______________ Normal?: Yes ☐ No ☐
Location of last mammogram Hoag ☐ Newport Imaging Center ☐
Newport Diagnostic Center ☐ Other ☐ ______________

Have you ever had any of the following (check yes if applicable)

Abnormal Pap smear	☐	Current pain with intercourse	☐
Genital herpes	☐	Current vaginal discharge or odor	☐
Genital warts/HPV	☐	Frequent yeast or bacterial infections	☐
Chlamydia	☐	Frequent urinary infections	☐
Gonorrhea	☐	DES exposure	☐

Breast lump ☐ Nipple discharge ☐ Breast pain ☐

What is your current method of contraception? Birth control pill/ring ☐ IUD ☐
Depo Provera ☐ Vasectomy ☐ Tubal ligation ☐ Condoms ☐ Rhythm ☐ No need ☐

MENSTRUAL HISTORY (if menstruating)

Age at 1st period ________ Date of 1st day of last period ________________

Number of days between periods (1st day to 1st day of next cycle) ______________

How many days do your periods usually last? __________

Please check if you answer yes to any of the questions below

Is heavy flow a problem? ☐ Do you bleed between periods? ☐

Do you have PMS? ☐ Do you bleed with intercourse? ☐

Do you have bad cramps? ☐

If so, what do you take for cramps? ____________

MIDLIFE/MENOPAUSE HISTORY (if menopausal or perimenopausal)

Please check if you answer yes to any of the symptoms below

Hot flashes	☐	Low sex drive	☐
Night sweats	☐	Loss of urine	☐
Trouble sleeping	☐	Urinary frequency	☐
Mood changes	☐	Vaginal dryness	☐

Colonoscopy	Date____________	Result______________________
DEXA scan	Date ___________	Result ______________________
Cholesterol screening	Date ___________	Result ______________________
Skin cancer screening	Date ___________	Result ______________________

HEALTH HABITS

Tobacco use Never ☐ Quit ☐ Date _________

Current smoker ☐ Packs per day _____ # of years _______

Alcohol intake Never ☐ Yes ☐ Drinks per week ________

Caffeine intake None ☐

Coffee ☐ _____ cups per day

Tea ☐ _____ cups per day

Soda ☐ _____ cans per day

Recreational drug use Never ☐ Previously ☐ Currently ☐ IV drug use ☐

Do you exercise regularly? Yes ☐ No ☐ How many times a week? _____

Do you eat a balanced diet? Yes ☐ No ☐

Are you currently dieting? Yes ☐ No ☐

Any history of eating disorder? Yes ☐ No ☐

Have you encountered physical or sexual abuse? ☐

REVIEW OF BODY SYSTEMS

Please check all that are applicable to your CURRENT reason for visit

Fever	☐	Chest pain	☐	Constipation	☐
Chills	☐	Palpitations	☐	Bloating	☐
Fatigue	☐	Shortness of breath	☐	Easy bruising	☐
Weight gain/loss	☐	Abdominal pain	☐	Headache	☐

CHRISTINE CHAI, MD

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that Dr. Chai will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit Dr. Chai only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with Dr. Chai to complete my annual exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that Dr. Chai will want to know how my condition progresses after I leave the office. Returning to see Dr. Chai on time gives her the chance to check my condition and my response to treatment. During a follow-up appointment, she might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that Dr. Chai will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that Dr. Chai's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from the office within 10 business days, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, Dr. Chai may make certain recommendations based on what she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow her recommendations so that she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

____________________ ________ ____________________

Patient Signature Date Physician Signature

Acknowledgement of Receipt of Notice of Privacy Practices

Christine Chai, MD
1441 Avocado Ave, Suite 309
Newport Beach, CA 92660

Privacy Officer: Raquel 949-631-1333
Effective Date: October 1, 2010

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signed:______________________________ Date________________

Print Name: ____

CHRISTINE J. CHAI, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 04/14/03,and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We may charge you a reasonable cost based fee for expenses such as staff time, copies and postage if you want them mailed to you. You may also request access by sending us a letter to the address in this Notice. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting **:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy Officer or with the Office for Civil Rights.

Privacy Officer: Karyn Krukow

Telephone: (949) 631-1333 Fax: (949) 650-5243

Address: 1441 Avocado Ave Ste 309
NEWPORT BEACH, CA 92660

Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14, 2002. Subsequent law changes may require Form revision.

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USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure, In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Health Information Exchange

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.