DIAGNOSTIC FNA CLINIC
MEDICAL LABORATORY SERVICES

ACCOUNT NUMBER: DOCTOR:

FIRST NAME	LAST NAME	M.I.	SEX M F
SSN	BIRTH DATE	AGE	
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	

PERSON TO CONTACT IN CASE OF EMERGENCY	
PHONE NUMBER	RELATIONSHIP

REFERRING PHYSICIAN	PHONE

Insurance Information

NAME OF INSURED/POLICY HOLDER		BIRTH DATE
SSN	RELATIONSHIP TO PATIENT	
PRIMARY INSURANCE INFORMATION		
NAME OF INSURANCE COMPANY		
POLICY TYPE HMO PPO POS EPO	POLICY I.D. #	
CLAIMS ADDRESS		
CITY	STATE	ZIP
COPAY AMOUNT		
SECONDARY INSURANCE INFORMATION		
NAME OF INSURANCE COMPANY		
POLICY TYPE HMO PPO POS EPO	POLICY I.D. #	
CLAIMS ADDRESS		
CITY	STATE	ZIP
COPAY AMOUNT		

WHAT ARE YOU BEING SEEN FOR TODAY?

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I hereby authorize this healthcare provider to release any information required in the course of treatment which shall include HIV, communicable disease, or drug abuse.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

SIGNED ____________________ DATE ____________________

DIAGNOSTIC FNA CLINIC • MEDICAL LABORATORY SERVICES
25470 MEDICAL CENTER DRIVE, SUITE 105, MURRIETA, CA 92562
(951) 834-9020 • FAX (951) 834-9026

AUTHORIZATION FOR FINE NEEDLE ASPIRATE

Your physician of record is Dr. ______________________________

The contact telephone number is ______________________________

1. The purpose of this form is to document that your physicians have discussed with you the surgical, diagnostic, or therapeutic procedure that your physicians have recommended that you undergo. You should read the form carefully and ask questions of your physicians before you decide whether or not to give your consent for this operation.
2. All operations and procedures may involve risks of unsuccessful results, complications, and injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedures, and the available alternative methods of treatment and their risks and benefits. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance.
3. Dr. Oh will be performing the FNA procedure. It is a minimally invasive procedure to remove and analyze fluid and cells from a cyst or mass.
4. The benefit of the procedure will be a preliminary diagnosis the day of the procedure. Your primary physician will also be able to advise you of the next step.
5. The most common complication is bruising and tenderness in the area of the biopsy. This is usually mild and will disappear in a few days.
6. Alternatives: Image-guided biopsy or open surgical biopsy.
7. Complications such as swelling, bleeding, or infection are rare. If these or any other unusual symptoms occur, please call Dr. Oh, or your primary physician, immediately.
8. You are making a decision whether or not to consent to the performance of the operation or procedure that is described in #3. Your signature on this informed consent indicates (1) that you have read and understood the information provided on this form, (2) that you have been verbally informed about this operation or procedure, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation or procedure, and (5) that you authorize and consent to the performance of the operation or procedure.

SIGNATURES FOR CONSENT (Print Legibly)

☐ Check, if information on this form has been discussed with the patient or legal representative.

PHYSICIAN OR NURSE OBTAINING CONSENT:

Name (PRINT)	Signature	Date/Time

PATIENT / PARENT / CONSERVATOR / GUARDIAN (If signed by other than the patient, indicate relationship):

Name (PRINT)	Signature	Relationship

WITNESS:

Name (PRINT)	Signature	Title (MD, RN, etc.)

Date/Time

NAME:

DOB:

DIAGNOSTIC FNA CLINIC
MEDICAL LABORATORY SERVICES

MEDICAL HISTORY

Date: ____________

Patient Name: ______________________________________ Birth Date: ______________

1. Medical / Surgical Problems (Past medical history including cancer or bleeding/bruising):

____

____

____

____

2. Medications: ____

____

____

____

3. Allergies (Latex or medications): ____

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4. Other: ____

____

____

____

BP ______________________________

Pulse ____________________________

Temp ____________________________