CENTRAL CARE CANCER CENTER HEARTLAND CANCER CENTER

Central Care Cancer Center | Heartland Oncology, LLC

PATIENT INFORMATION: *To Be Completed By All Patients Upon Initial Consultation*

Patient Name_____ Date of Birth_____/_____/_____

Sex: M F Marital Status: M S D W Social Security Number _____

Mailing Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

E-Mail Address:_____ Preferred Language: _____

Employer:_____ Employment Status: _____

Circle One:

Race: White African American Asian Other

Circle One:

Ethnicity: Hispanic/Latino Not Hispanic/Latino

PHYSICIAN INFORMATION:

Referring Physician:_____ Primary Care Physician: _____

City, State:_____ City, State:_____

Phone Number:_____ Phone Number: _____

ADVANCED DIRECTIVES

Do you have a Living Will? Yes No Do you have a Power of Attorney for Health Care Decisions? Yes No

INSURANCE INFORMATION *Please bring all insurance cards with you.

Primary Insurance:

Insurance Company Name_____ Address _____

Policyholder_____ ID#_____ Group_____

Policyholder Date of Birth_____/_____/_____ Policy Holder Social Security Number _____

Secondary Insurance:

Insurance Company Name_____ Address _____

Policyholder_____ ID#_____ Group_____

Policyholder Date of Birth_____/_____/_____ Policy Holder Social Security Number _____

*If Medicare is secondary:

1. Do you work full-time w/insurance benefits? Yes No
2. Do you receive insurance thru a spousal employer? Yes No
3. Do you receive Medicare due to: End Stage Renal Disease? Yes No Due to Disability? Yes No
4. Do you have a Federal Black Lung Card? Yes No
   If Yes, Are you entitled to benefits under the Department of Labor's Black Lung Program? Yes No
5. Are you a Veteran referred here for treatment? Yes No VA Fee Basis ID Card? Yes No
   If Yes, Do you authorize us to bill the VA? Yes No

Prescription Insurance (if different from above):

Insurance Company Name_____ Address_____

Policyholder_____ ID#_____ Group_____

Cancer Insurance:

Cancer Insurance Company Name:_____ Will you need an itemized bill? Yes No

Patient or Legal Guardian Signature:_____ Date _____

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow Central Care, P.A. to disclose the following Protected Health Information:

_____ Appointment Dates and Times

_____ Tests Results

_____ Billing Information

_____ Other Health Information

To the following people because they are involved with my healthcare or payment:

_____ Self

_____ Spouse Name: _____ Phone: _____

_____ Family Friend Name: _____ Phone: _____

_____ Child Name: _____ Phone: _____

_____ Child Name: _____ Phone: _____

_____ Other Name: _____ Phone: _____

_____ Other Name: _____ Phone: _____

In the following forms of communication:

_____ Home Telephone

_____ Work Telephone

_____ Home Voice Messaging system

_____ Work Voice Messaging system

_____ Cellular Phone

_____ Other _____

Please send appointment reminders via:

_____ Email

_____ Text Message (cell phone)

_____ Voice Message

_____ None-I do not wish to receive reminders

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth

CONSENT TO AND CONDITIONS OF TREATMENT

Central Care Cancer Center and Heartland Oncology, LLC are herein after referred to as "The Cancer Center". Any and all physicians providing medical care and treatment, including consultations, during the course of my treatment are herein after referred to as "physicians".

1. **CONSENT FOR TREATMENT**: Knowing that I have a condition requiring diagnosis and medical treatment, I do hereby consent to and authorize all medical treatment, laboratory, and other medical procedures as may be performed or prescribed by my physician or any persons including other physicians, assistants, and personnel who assist in my treatment. I further acknowledge that no guarantees have been made to me regarding the success of my examination or treatment at The Cancer Center.

2. **RELEASE OF INFORMATION**: I HEREBY AUTHORIZE The Cancer Center, physicians and staff to release any or all of my medical record, verbally, via fax machine, via photocopy, via encrypted data, or via onsite review to other healthcare institutions that I may be transferred to, or am being evaluated for transfer to, cancer and immunization registries, and agencies or physicians that may become involved in further treatment or follow-up care. I further authorize The Cancer Center to release any or all information to my insurance company, third party payor, or assistance foundation for utilization review purposes and for the purpose of processing my claim and obtaining payment of the account of The Cancer Center and physician for medical care and treatment provided. I will hold harmless The Cancer Center, physicians, and staff should my information unintentionally fall into the wrong hands.

3. **PRIVACY NOTICE, PATIENT RIGHTS AND FINANCE POLICIES**: I acknowledge that I have been given the opportunity to receive a copy and/or have been instructed to read the The Cancer Center Privacy Notice/Patient Rights and Financial Policies, and that I can view these at any time as they are available in the reception area and online at cccancer.com.

4. **MEDICARE/MEDICAID AUTHORIZATION**: I hereby authorize The Cancer Center, physicians, and staff to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, review organizations, or any peer review organization, any information needed for Medicare and/or Medicaid claim. I request the payment of authorized benefits to be made on my behalf to The Cancer Center and the physicians for medical care and treatment, including consultations provided to me. I certify that the information given to me in applying for payment under Title XVII and Title XIX of the Social Security Act is correct.

5. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby authorize the payment of, and assign payment directly to The Cancer Center and the physicians, of any major medical or basic health insurance benefits, and/or assistance foundation benefits payable to me. I understand that I am responsible for charges not covered by this assignment and further agree to make full payment of all medical expenses which are not covered by insurance, third party payors, or foundations.

6. **PRE-CERTIFICATION/AUTHORIZATION FOR INSURANCE:** It is my responsibility to obtain pre-certification and/or authorization of professional services if required by my insurance carrier. I understand that if I have treatment, labs, or any other medical service without certification or authorization, I will be personally responsible for all of the cost of treatment and professional services not paid by my insurance carrier.

7. **ANCILLARY SERVICES:** You may receive ancillary medical services while a patient of The Cancer Center such as: telemedicine appointments, laboratory services, imaging services (e.g., CTs, PET scans), interpretation of tests, and pathology specimen examination. By signing below, you understand that some providers may not provide services in your presence, but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

8. **GUARANTEE OF PAYMENT**: The undersigned spouse, policy holder, or guarantor, if other than the patient identified below to whom medical services will be rendered, in consideration of services to be rendered to the patient identified, does herby guarantee payment of the medical expense for such services, including the charges of The Cancer Center and physicians.

CONSENT TO AND CONDITIONS OF TREATMENT CONTINUED. . .

MY SIGNATURE BELOW INDICATES THAT THE INFORMATION I PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE AND I HAVE READ THIS AGREEMENT AND UNDERSTAND IT FULLY:

Print Name of Patient	Date
Signature of Patient	If other than the patient, state relationship and reason for signing for the patient.
Signature of Relative or Legal Guardian	
Signature of Spouse, Policyholder, or Guarantor	Witness/Translator

PATIENT HEALTH HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Read & Write English: Yes ☐ No ☐

Diagnosis: _____

Nursing Home Status: _____ Skilled Care: _____

Reason for Visit: _____

Name of Primary Physician: _____

Other Physicians involved in your care at this time: _____

ALLERGIES: Are you *allergic to any medications?* Yes ☐ No ☐ If yes, list below:

Medication Type of Reaction

_____

_____

_____

Have you had contrast dye?

Yes ☐ No ☐

Are you allergic to contrast dye?

Yes ☐ No ☐

Type of Reaction: _____

CURRENT MEDICATIONS*: Please **list** the medications, vitamins, or herbal supplements that you are presently taking below:*

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with cancer before? Yes ☐ No ☐

Describe: _____

Were you ever treated with Radiation/Cobalt or Chemotherapy? Yes ☐ No ☐

Describe: _____

Have you ever had a blood or platelet transfusion? Yes ☐ No ☐

Date of last transfusion: _____

Have you ever been diagnosed with Diabetes? Yes ☐ No ☐ Type I ☐ Type II ☐

Are you claustrophobic? Yes ☐ No ☐

PLEASE CHECK YOUR PHYSICAL ABILITY USING THIS KARNOFSKY SCALE:

- ☐ 20% Very sick, hospitalized, active support needed
- ☐ 30% Severely disabled, needs hospitalization, death not imminent
- ☐ 40% Disabled, needs special care and assistance
- ☐ 50% Requires frequent medical help and considerable assistance
- ☐ 60% Able to care for most needs, requires occasional help
- ☐ 70% Unable to do active work, but able to care for self
- ☐ 80% Normal activity, but requires effort
- ☐ 90% Normal, only minor signs and symptoms
- ☐ 100% Normal, no complaints

*Please **check** the items that apply to your medical history:*

- ☐ Diabetes
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease (CAD)
- ☐ Pacemaker/Defib-Provide Card
- ☐ Cardiac Arrhythmia
- ☐ History of Heart Attack
- ☐ Tuberculosis
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Pulmonary Embolism
- ☐ Emphysema
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Liver Disease
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Gastrointestinal Bleed
- ☐ Acid Reflux
- ☐ Blood Disorder
- ☐ Sickle Cell Disease
- ☐ History of Blood Clots
- ☐ Arthritis
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Joint Replacement/Metal in Body
- ☐ Other:_____

_____

_____

Gynecological (Female)

Age at onset of menses: _____

Date of last menstrual cycle: _____

Number of Pregnancies:_____ Living Children: _____ Miscarriages:_____

PAST SURGICAL HISTORY: *Please **list** any surgery that you have had below:*

Operation	Date	Hospital

PREVENTIVE CARE AND SCREENING: *Please enter the date of your last:*

Mammography:_____ PAP smear/Pelvic Exam: _____ PSA:_____

Colonoscopy: _____ Flu Shot:_____

SOCIAL HISTORY:

Marital Status: Select One

Last Year of School Completed: _____

Occupation: (Present)_____ (Past) _____

Children (Gender & Ages)_____

Siblings (Gender & Ages)_____

Home Support: Yes No

HABITS:

Cigarettes:_____pack/day for_____years._____When did you quit? _____

Alcohol:_____# of drinks (*Please **check** box*): per day week month

Recreational drugs: _____

Exposure to toxic chemicals: Yes No

HEALTHY HABITS:

Dietary Habits: _____

Exercise Routine: _____

Religious Preference: _____

PAST INJURIES: *Please **list** any major injuries that you have had below:*

Injury	Date	Treatment

FAMILY HISTORY: *Please **list** any history of cancer or blood disorders that are present in your immediate family – grandparents, parents, sisters, brothers, children:*

Relationship to You	Type of Cancer/Blood Disorder	Age at Diagnosis

Parental Status:

Mother – *Please **check one:*** Living Deceased

If deceased, cause and age of death:

Father – *Please **check one:*** Living Deceased

If deceased, cause and age of death: _____

Number of Daughters:_____ Number of Sons: _____

Sibling Status: Number of Sisters:_____ Number of Brothers:_____

REVIEW OF SYSTEMS: *Please **check** the items that apply to your health history:*

 # 1 GENERAL:

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Night Sweats
- ☐ Use walker/wheelchair
- ☐ Require assistance with daily activities

 # 2 EYE:

- ☐ Blurred vision
- ☐ Swelling of eye
- ☐ Contacts/glasses
- ☐ Cataracts/surgery
- ☐ Double vision
- ☐ Eye pain
- ☐ Watery eyes
- ☐ Impaired vision
- ☐ Legally blind
- ☐ Traumatic injury of the eye
- ☐ Optometrist/ophthalmologist:_____

 # 3 ENT/MOUTH:

- ☐ Thrush
- ☐ Congestion
- ☐ Trouble Swallowing
- ☐ Earache
- ☐ Ear Infection
- ☐ Nose Bleed
- ☐ Gum Bleeding
- ☐ Hay Fever
- ☐ Hearing Loss
- ☐ History of Dental Problems
- ☐ Hoarseness
- ☐ Nasal Obstruction
- ☐ Oral Dryness
- ☐ Oral Ulcers
- ☐ Painful Swallowing
- ☐ Sinus Pain
- ☐ Sore Throat
- ☐ Ringing in Ears- Tinnitus
- ☐ Dizziness
- ☐ Dentures
- ☐ Last Dental Appt:_____
- ☐ Dentist:_____

#4 CARDIOVASCULAR:

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Swelling
- ☐ Syncope/Fainting
- ☐ Cardiologist:_____

#5 RESPIRATORY:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Chest Wall Trauma
- ☐ Cough
- ☐ Shortness of Breath-Dyspnea
- ☐ Coughing up Blood
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Oxygen
- ☐ Pulmonologist: _____

#6 BREAST:

- ☐ Underarm Pain
- ☐ Breast Mass
- ☐ Breast Tenderness
- ☐ Change in Size
- ☐ Change in Shape
- ☐ Swelling of Breast
- ☐ Breast MRI
- ☐ Breast Ultrasound

#7 GASTROINTESTINAL:

- ☐ Abdominal Bloating
- ☐ Abdominal Cramping
- ☐ Blood in Stool-Melena or Hematochezia
- ☐ Change in Bowel Movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion-Dyspepsia
- ☐ Stool Incontinence
- ☐ Flatulence
- ☐ Vomiting blood- Hematemesis
- ☐ Hemorrhoids
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ GERD
- ☐ Ulcers
- ☐ Vomiting
- ☐ Difficulty Swallowing-Dysphagia
- ☐ Painful Swallowing-Odynophagia

#8A GENITOURINARY:

- ☐ Bladder Spasm/Pain
- ☐ Burning with Urination
- ☐ Cloudy Urine
- ☐ Dark Urine
- ☐ Foul Smelling Urine
- ☐ Blood In Urine
- ☐ Urinating at Night-Nocturia
- ☐ Low Urine Output-Oliguria
- ☐ High Urine Output-Polyuria
- ☐ Urinary Hesitancy
- ☐ Incontinence
- ☐ Urinary Tract Infection

#8B MALE GENITOURINARY:

- ☐ Catheter
- ☐ Groin Skin Changes
- ☐ Impotence
- ☐ Scrotal Swelling
- ☐ Straining to Urinate
- ☐ Testicular Mass
- ☐ Testicular/Scrotal Pain
- ☐ Blood in Semen
- ☐ Last Urology Appt: _____
- ☐ Urologist: _____

#9 FEMALE GYNECOLOGICAL :

- ☐ Abnormal Bleeding
- ☐ Abnormal Menstrual Periods
- ☐ Changes in Menses
- ☐ Dry Vaginal Mucosa
- ☐ Pain During Period-Dysmenorrhea
- ☐ Painful Intercourse-Dyspareunia
- ☐ Pelvic Pain
- ☐ Rash
- ☐ Post-coital Bleeding- Bleeding after sex
- ☐ Spotting
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Last Gynecology Appt: _____

 # 10 MUSCULOSKELETAL:

- ☐ Walk with walker/cane
- ☐ Joint pain – Arthralgia
- ☐ Back pain
- ☐ Bone pain
- ☐ Fracture
- ☐ Joint swelling
- ☐ Joint redness
- ☐ Limited joint movement
- ☐ Muscle weakness
- ☐ Muscle pain – Myalgia
- ☐ Neck/back trauma
- ☐ Spine tenderness

#11 SKIN:

- ☐ Hair Loss-Alopecia
- ☐ Dry Skin
- ☐ Redness-Erythema
- ☐ Yellow Skin
- ☐ Itching
- ☐ Rash
- ☐ Skin Color Change
- ☐ Skin Lesions
- ☐ Skin Cancer
- ☐ Excessive Sun Exposure
- ☐ Sunburns Easily
- ☐ Tans Easy
- ☐ Dermatologist:_____

 # 12 NEUROLOGICAL:

- ☐ Language difficulty – Aphasia
- ☐ Loss of energy – Asthenia
- ☐ Involuntary body movement – Atari
- ☐ Blackout
- ☐ Confusion
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Falls
- ☐ Headache
- ☐ Hiccups
- ☐ Memory loss
- ☐ Numbness
- ☐ Pain
- ☐ Seizures
- ☐ Speech change
- ☐ Fainting
- ☐ Tingling – Paresthesia
- ☐ Neurologist: _____

 # 13 PSYCHIATRIC:

- ☐ Anxiety
- ☐ Hallucinations
- ☐ Depression
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Poor Concentration
- ☐ Sleep Disorder
- ☐ Suicidal Attempts/Thoughts
- ☐ Psychiatrist:_____

#14 ENDOCRINE:

- ☐ Sensitive to cold
- ☐ Sensitive to heat
- ☐ Hot flashes, menopausal

#16 LYMPHATIC:

- ☐ Swollen Lymph Nodes-Lymphadenopathy
- ☐ Painful Lymph Nodes
- ☐ Autoimmune Disease

#15 HEMATOLOGIC:

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Easy Bruising
- ☐ Nose Bleed-Epistaxis
- ☐ Increased Bleeding
- ☐ Excessive Bleeding on Tooth Extraction
- ☐ Fatigue

#17 ALLERGY:

- ☐ Eczema
- ☐ Frequent infections
- ☐ Pollen allergies
- ☐ Recurrent sinus infections
- ☐ Recurrent skin infections
- ☐ Recurrent hives

PAIN LEVEL: (Current or Within Past 7 days) Please Check One:
Scale from 0-10 (With Zero being "No Pain" and Ten being "The MOST pain you've ever had")

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Location of Pain:_____

What have you done for your pain: _____

ADDITIONAL INFORMATION:

I certify that the above information is correct to the best of my knowledge. I will not hold by doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient's Signature Date

_____ _____
Nurse's Signature Date

_____ _____
Physician's Signature Date

For Nurse to complete:
Height: _____Weight_____ BP____/_____ P_____ R_____ Temp_____ O2 _____

Name: _____ Date of Birth: _____ Date: _____

Please complete and sign this form to help us provide you with the best care.

I'M DOING FINE – NO CONCERNS AT THIS TIME ❑

Rate each of the following by circling the number that represents your level of concern:

1-Not a problem 2-Mild Problem 3-Moderate Problem
4-Severe Problem 5-Very Severe Problem

Please circle **YES** if you would like a member of our staff to contact you.

Work Related Issues	1	2	3	4	5	**YES**
Medical Bills/Insurance	1	2	3	4	5	YES
Lodging	1	2	3	4	5	YES
Paying for Food	1	2	3	4	5	YES
Transportation	1	2	3	4	5	YES
Sadness/Depression	1	2	3	4	5	YES
Anxiety, Worry or Fear	1	2	3	4	5	YES
Difficulty Coping	1	2	3	4	5	YES
Spiritual/Religious Concerns	1	2	3	4	5	YES
Sleeplessness	1	2	3	4	5	YES
Nutrition/Dietitian	1	2	3	4	5	YES

Patient Signature: _____

To Be Completed by Provider:

Comments: _____

Refer to (Please Circle): **Dietitian** **Financial Counselor** **Social Worker** **Home Health** **Chaplain** **Hospice** **Emotional Health** **Palliative Care** **Support Group** **Travel Assistance**

Provider Initial: _____ Date _____