

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
**If yes, please bring a copy to your next appointment*

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 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:

Please send appointment reminders via:

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone | <input type="checkbox"/> Email |
| <input type="checkbox"/> Work Telephone | <input type="checkbox"/> Text Message (cell phone) |
| <input type="checkbox"/> Home Voice Messaging system | <input type="checkbox"/> Voice Message |
| <input type="checkbox"/> Work Voice Messaging system | <input type="checkbox"/> None-I do not wish to receive reminders |
| <input type="checkbox"/> Cellular Phone | |
| <input type="checkbox"/> Other _____ | |

 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 hereby 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 Care Physician: _____
 Other Physicians involved in your care at this time: _____

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

<u>Medication</u>	<u>Type of Reaction</u>

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:

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

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.*

<u>Operation</u>	<u>Date</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

Colonoscopy: _____ Flu Shot: _____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Widowed

Last Year of School Completed: _____

Occupation: (Present) _____ (Past) _____

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:*

<u>Injury</u>	<u>Date</u>	<u>Treatment</u>

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

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

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

If deceased, cause and age of death: _____

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

If decease, cause and age of death: _____

Children (Gender & Ages) _____

Siblings (Gender & Ages) _____

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
- Double Vision
- Cataracts/surgery
- 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

#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

#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: _____

#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: _____

Difficulty Swallowing-Dysphagia

#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: _____

#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

#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

#15 LYMPHATIC:

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

#16 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 7days) 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 my 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____