NEW PATIENT FORMS

(Please Print. Thank You.)

Patient Name: ______________________ **Date of birth:** __________

Address: ______________________ **Social Security Number:** __________

City: ______________ **State:** ______________ **Zip Code:** ______________

Secondary Address: ______________________

City: ______________ **State:** ______________ **Zip Code:** ______________

Home Phone: ______________ **Cell Phone:** ______________

May we leave a message on your answering machine / voicemail? ☐ **Yes** ☐ **No**

Email Address: ______________________

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American

☐ Asian/Pacific Islander ☐ Other

Pharmacy: ______________________

Name Address City State

EMERGENCY CONTACT (PARENT/GUARDIAN IF PATIENT IS A MINOR)

Name: ______________________ **Relationship:** ______________

Home Phone: ______________ **Cell Phone:** ______________

Power of Attorney (if applicable): ______________ **Relation to You:** ______________

Living Will: ☐**Yes** ☐**No** *Please provide a copy for your record

I certify that the information I will give today is to the best of my ability and as fully accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

______________________ ______________

PATIENT SIGNATURE **DATE**

______________________ ______________

PATIENT LEGAL GUARDIAN/REPRESENTATIVE OR PARENT **DATE**

Primary Care Physician: ______________________________ Phone #: ______________

Referring Physician (if different): ______________________ Phone #: ______________

Please list any additional Physicians you see: (Include Phone #):

______________________________________ Phone #: ______________

______________________________________ Phone #: ______________

______________________________________ Phone #: ______________

______________________________________ Phone #: ______________

______________________________________ Phone #: ______________

Insurance

Primary Insurance Carrier: ______________________________________

Name of primary policy holder: ______________________________________

Policy holder's Date of Birth: ____________________ Policy holder's SS#: ______________

Policy holder's employer: ______________________________________

Policy holder's employer address: ______________________________________

Policy holder's employer phone number: ______________________________________

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: ______________________________________

Name of secondary policy holder: ______________________________________

Policy holder's Date of Birth: ____________________ Policy holder's SS #: ______________

Policy holder's employer: ______________________________________

Policy holder's employer address: ______________________________________

Policy holder's employee phone number: ______________________________________

Does plan have prescription coverage? ☐ Yes ☐ No

<u>REASON FOR THIS VISIT</u>: ______________________________________

CANCER HISTORY:

Type: ______________________________ **Date Diagnosed:** __________

Treatment: (Type, Date, location of treatment, and Physician)

Previous Radiation Therapy: ______________________________

Previous Chemotherapy: ______________________________

Previous Surgery: ______________________________

MEDICAL HISTORY:

(Check the items that apply to you, currently or in the past)

☐ None
☐ Anemia
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clots
☐ Blood Disorder
☐ Frequent infections
☐ HIV / AIDS
☐ Diabetes
☐ Thyroid Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Atrial Fibrillation
☐ Congestive Heart Failure
☐ Heart Attack-MI
☐ Heart Disease
☐ Rheumatic Fever
☐ Heartburn / Reflux
☐ Heart Murmur
☐ Irregular Heart Beat
☐ Peripheral Vascular Disease

☐ Chronic Lung (COPD)
☐ Pneumonia/Bronchitis
☐ TB (Tuberculosis)
☐ Sleep Apnea

☐ Colon Polyps
☐ Crohn's Disease
☐ Diverticulitis
☐ Irritable Bowel Syndrome
☐ Ulcerative Colitis
☐ Stomach Ulcers
☐ GERD/Heartburn
☐ Hiatal Hernia
☐ Gallstones
☐ Cirrhosis of Liver
☐ Hepatitis A /B / C
☐ Pancreatitis
☐ Kidney Stone
☐ Kidney Disease/Failure
☐ Enlarged Prostate
☐ Lupus-Autoimmune
☐ Reynaud's Syndrome

☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Chronic Back Pain
☐ Osteoporosis
☐ Fracture
☐ Stroke
☐ Neuropathy
☐ Parkinson's disease

☐ Paralysis
☐ Seizures
☐ Migraines
☐ Shingles
☐ Glaucoma/Cataracts
☐ Hearing Loss
☐ Cancer
☐ Leukemia
☐ Lymphoma
☐ Anxiety
☐ Depression
☐ Drug Use
☐ Problems w/Anesthesia
☐ Freq. Urinary Tract InfectionS

Health Maintenance:

Sigmoidoscopy / Colonoscopy: ☐ Yes ☐ No Date: ________ Findings: ______________________________

Last Mammogram Date: __________ Last Bone Density Date: ________ Last Pelvic Exam Date: ________

Influenza (Flu) Shot Date: ___________ Pneumococcal Shot Date: ___________

Last Shingles Shot Date: ____________ Last EGD Date: ____________

PAST SURGICAL HISTORY:

(Please circle and date any of the surgeries and/or procedures that you have undergone)

Coronary Bypass Date:____________
Angioplasty Date:____________
Pacemaker Date:____________
Cardiac Valve surgery Date:____________
Hemorrhoidectomy Date:____________
TURP Date:____________
Hernia Repair Date:____________
Tonsillectomy Date:____________
Mastectomy Date:____________
Knee Replacement Date:____________
Rotator Cuff Repair Date:____________
Cataract Date:____________
Gallbladder surgery Date:____________
Hysterectomy Date:____________
Prostatectomy Date:____________
Appendectomy Date:____________
Hip Replacement Date:____________
Lumpectomy Date:____________

Other Operations: ___________________________________

MEDICATION LIST:

Your treatment can be affected by any medication that you take. It is important that your physician has updated and correct information.

List **ALL** medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Ordering Physician

ALLERGIES: List all medication allergies

Medication: ____ Reaction: ______________________________

Medication: ____ Reaction: ______________________________

Are you allergic to:

☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye / IV Contrast ☐ Eggs ☐ Peanuts

Other: ____

Type of reaction: ____

FAMILY MEDICAL HISTORY:
Indicate any family members with cancer, blood disease or other disease

	Age	Disease	If deceased, cause of death
Father:	______	______________________	______________________
Mother:	______	______________________	______________________
Siblings:	______	______________________	______________________
	______	______________________	______________________
	______	______________________	______________________
Children:	______	______________________	______________________
	______	______________________	______________________

In your opinion, are there any diseases that run in your family? ☐ Yes ☐ No
Please list: ____

SOCIAL HISTORY:

Birth City: ______________________________ Birth State: ______________________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Children: ☐ Yes ☐ No Number of Children: __________

Employment Status: ☐Full-Time ☐Part-Time ☐Student ☐Retired **Retired Date:** ________________

Occupation (Former if Retired):____

Employer (Former if Retired): ____

Military History:
Have you ever served in the military? ☐ Yes ☐ No

If yes, service branch and duties: ____

Years in service: ________________

Agent Orange Exposure ☐ Yes ☐ No

Tobacco Use: (Present &/or Past)
☐ **Never Smoked**
☐ **Quit Smoking When? ______ How many years did you smoke?** ____yr(s) **How many packs?** ___/day
☐ **Currently Smoke** ☐ **Cigarettes** ☐ **Pipe** ☐**Cigars** ☐ **Chewing Tobacco**

Alcohol Use:
☐ **Non Drinker**
☐ **Beer** number of bottles ____________ per ☐ **Day** ☐ **Week** ☐ **Month**
☐ **Wine** number of glasses ____________ per ☐ **Day** ☐ **Week** ☐ **Month**
☐ **Liquor** number of glasses ____________ per ☐ **Day** ☐ **Week** ☐ **Month**

REVIEW OF SYSTEMS:
(Please check any **current** symptoms you have.)

General:
☐ Weight loss
How much___________
Over what time period _______
☐ Fevers
Max temp __________
☐ Chills
☐ Night Sweats
☐ Fatigue

Eyes:
☐ Wear Glasses/Contact Lenses
☐ Blurred Vision
☐ Double Vision

Ears, Nose, Throat:
☐ Hard of hearing or deaf
☐ Ringing in ears
☐ Enlarged lymph nodes
☐ Chronic sinus problems
☐ Sore throat
☐ Mouth pain/sores

Changes/Difficulty In:
☐ Taste
☐ Smell
☐ Voice

Cardiovascular:
☐ Chest pain/Angina Pectoris
☐ Palpitations/heart murmur
☐ Irregular heart beat pressure

Respiratory:
☐ Chronic or Frequent Cough
☐ Bloody Sputum
☐ Shortness of breath

Gastrointestinal:
☐ Difficult or painful swallowing
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Indigestion
☐ Lump or sensation in throat
☐ Food Sticking
☐ Bloating
☐ Belching
☐ Diarrhea
☐ Constipation
☐ Rectal Bleeding
☐ Black or tarry stools
☐ Blood in stool
☐ Excessive rectal gas/flatus
☐ Loss of stool/fecal accident
☐ Poor appetite
☐ Jaundice

Genitourinary:
☐ Kidney Stones
☐Pelvic Pain
☐ Incontinence
☐ Burning or pain in urination
☐ Blood in urine
☐ Difficult urination
☐ Men: Prostate problems

Musculoskeletal:
☐ Joint Pain/Arthritis
☐ Muscle or joint weakness
☐ Back pain
☐ Bone pain
☐ Muscle aches

Neurologic:
☐ Numbness, tingling
☐ Arm or leg weakness
☐ Light-headed, dizzy, fainting spells
☐ Headache

Skin:
☐ Rashes or itching
☐ Change in skin color or moles
☐ Varicose vein
☐ Skin Cancer

Psychiatric:
☐ Anxiety/Agitation
☐ Depression
☐ Crying for no reason
☐ Insomnia
☐ Alcoholism
☐ Drug Problem (Now/Past)

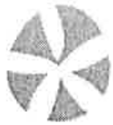
Hematologic:
☐ Easy bruising
☐ Gum or nose bleeding
☐ Blood transfusion in the past

Allergies/Immunology:
☐ History of chronic infections
☐ History of allergies

Endocrine:
☐ Heat or cold intolerance
☐ Excessive skin dryness
☐ Excessive thirst or urination
☐ Weight problem
☐ Hot flashes

Breast:
☐ Rashes or itching
☐ Change in skin color or moles
☐ Varicose veins
☐ Skin cancer

Gynecologic:
Age at start of menses _______
Last menstrual period ________
☐ Breast pain/lump
☐ Breast discharge or rash
☐ Vaginal discharge
☐ Menstrual irregularity
☐ Hormone replacement therapy?
Use? ___________________
If Yes, How long? __________



Financial Policy Information

We are please you have chosen Florida Radiation Oncology for your patient services.

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have put together this financial policy sheet.

Commercial Insurance: Florida Radiation Oncology will bill insurance provided that your carrier will make payment directly to our office. In the even your insurance company does not pay for billed services, the balance will be your responsibility. We will verify the insurance coverage and let you what, if any, percentage you will be responsible to pay. Payment is due on the date of service. **Please notify us of any changes in insurance coverage prior to time of service.**

Medicare & Medicaid: Please be advised that all Medicare/Medicaid claims will be filed through our billing agency. Our doctors are participating physicians and accept Medicare assignment. This means that Medicare will send a check to our office for payment of services rendered. As a courtesy to you, we will submit the co-insurance to your secondary carrier if Medicare had not already done so. These payment deductions will be seen in your monthly statements. If you do not have a secondary carrier, please be advised that Medicare requires us to collect the yearly deductible and the 20% balance on all allowed charges by law.

Insurance Release: I authorize Florida Radiation Oncology to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including; medical, psychiatric, laboratory studies, HIV testing, and other medical data related to my care. I authorize any insurer or payer to make payment directly to Florida Oncology Tavares. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

Financial Agreement: I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. Our front desk staff will ask you for payment for any past due balances as well as your portion of the payment for today's service. This includes co-pays, co-insurances and deductibles. Should the account be referred to a collection agency or attorney for collection,

the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

Out-of-Network & Self-Paying Patients: As a service to you, we would like to meet with you so that we can arrange a payment plan that would be comfortable for both you and our office. We will be happy to discuss any questions that you might have.

We accept cash, personal check, VISA, MasterCard, Discover, and American Express credit cards. There is a $40.00 service charge for returned checks.

Thank you for your cooperation. We hope this has answered any questions.

______________________________ ______________

Print Patient Name Date of Birth

______________________________ ______________

Signature of Patient, Parent or Legal Guardian/Representative Date

FLORIDA RADIATION ONCOLOGY
WINTER PARK

REQUEST FOR RELEASE OF RECORDS

I, ______________________________, request a copy of my complete medical record from the office of:

____

____

Name and Address of Practitioner

To be sent to:

Florida Radiation Oncology
483 N. Semoran Blvd, Ste 107
Winter Park, Florida 327928

	Item		Item
●	Office Visit Note	●	MRI films and reports
●	Pathology Report	●	Bone scan films and reports
●	Operative Report	●	Lab Results
●	Discharge Summaries	●	Radiation Treatment Records
●	CT scans and reports	●	Simulation/Port Films
Other:			

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Radiation Oncology to receive copies of any medical, psychiatric, Aids, Aids relates syndromes, HIV testing, Alcohol and/or drug abuse related information from the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire ninety (90) days after the date below or sooner at my election.

______________________________ ______________________________

Print Patient Name Date of Birth

______________________________ ______________________________

Signature Patient, Parent or Legal Guardian/Representative Date

HIPAA – Others Involved In Health Care

As a patient of Florida Radiation Oncology, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. The information provided on this page will be valid for one year from the date of signature. This information can be changed or revoked with your permission at any time.

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

I give permission for information related to my current health status to be discussed with:

____

Name Relationship Telephone

____

Name Relationship Telephone

____

Name Relationship Telephone

____

Name Relationship Telephone

____

Name Relationship Telephone

Patient Name: ______________________________ **Date of Birth:** ____________

Print Name

Signature: ________________________________ **Today's Date:** __________

Patient or Legal Representative