Carolina Oncology Specialists

A Partner of OneOncology

Today's Date _____/_____/_____

Patient Information Form

Name of Patient:_____Date of Birth:_____Age: _____

Home Address:_____County:_____

City, State, Zip: _____

Mailing Address (if different):_____

Home Phone: (___)_____Cell:(___)_____Work:(___)_____

Email Address: _____

Social Security Number: _____Sex: ☐Male ☐Female

Marital Status: ☐Single(Never Married) ☐Married ☐Life Partner ☐Divorced/Separated ☐Widowed

Race: ☐African American or Black ☐Asian ☐Hispanic ☐White ☐American Indian or Alaska Native ☐Native Hawaiian or other Pacific Islander ☐Other_____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Preferred Language: ☐ English ☐Spanish ☐Other _____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Active Military ☐Retired Military ☐Self Employed ☐Disabled ☐Retired, date of Retirement: _____

Employer and Address:_____

Insurance Information:

Primary Insurance Co._____ ID:_____

Secondary Insurance Co:_____ ID: _____

ADDITIONAL INFORMATION NEEDED FOR PROCESSING OF INSURANCE:

Do you have employer group health coverage? Yes☐ No☐ If yes, are you still working? Yes☐ No☐

Are you covered through your spouse's insurance? Yes☐ No☐ If yes, their date of birth:____/____/_____

Does his/her employer have more than 50 employees Yes☐ No☐ Is your spouse still working? Yes☐ No☐

Are you a resident of a skilled nursing facility? Yes☐ No☐ If yes, answer the next facility questions.

Name of Facility_____ Facility Address: _____

Facility Phone Number: _____ Does insurance pay for the stay? Yes☐ No☐

Prescription Drug Coverage:

Do you have prescription drug coverage? Yes☐ No☐ If yes, please list below and provide a copy to us.

Prescription Drug Insurance Carrier_____

Pharmacy:

Pharmacy:_____ Pharmacy Location:_____

Pharmacy Phone: _____

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Patient Name: _____

Date of Birth: _____

AUTHORIZATIONS AND CONSENT

Authorization to pay benefits to the physician: I hereby authorize payment directly to Carolina Oncology Specialists, PA for any services furnished to me by this provider. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid directly to me.
Person responsible for payment if patient is unable to pay:

Name: _____ Relation: _____ Phone #_____

Consent for purposes of treatment, payment and healthcare operations: I hereby consent to treatment by Carolina Oncology Specialists, PA. I also consent to the use or disclosure of my protected health Information by COS for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of COS. I understand that diagnosis and/or treatment may be conditional upon consent.

Acknowledgment of Receipt of Notice of Privacy Practices: I have received a copy of Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

ADVANCED PRACTITIONER (NP/PA) CONSENT

Carolina Oncology Specialists, PA utilizes Physician Assistant's and Nurse Practitioner's in our office for the levels of our practice that have been approved by the North Carolina State Board of Medical Examiners.
I confirm my agreement to being treated by a Physician Assistant or Nurse Practitioner who is under the supervision of the physicians with Carolina Oncology Specialists, PA, by signing below.

Patient Signature:_____**Date:** _____

AUTHORIZATION TO PROVIDE CONTRACTED SERVICES

During your care at Carolina Oncology Specialists, PA, your physician may prescribe medications. You have the option of receiving these services from the dispensary/pharmacy of your choice.

Dispensary Services

Carolina Oncology Specialists, PA could provide you with many prescribed medications through Carolina Oncology Specialists, PA, a dispensary in which the physician owners have an investment interest. These medications may be dispensed by your physician and transferred to you if you desire. If needed, a pharmacist/physician is available to provide you with counseling concerning your medications.

In addition to Carolina Oncology Specialists, PA, there are local pharmacies in the area that may fill your prescription.

I understand that I have an option of receiving my prescriptions from the provider of my choice.

Patient Signature:_____**Date:** _____

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Patient Name: _____

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HIPAA Information

☐ I do not authorize Carolina Oncology Specialists, PA to communicate with anyone other than me, excluding all disclosures allowed by law.

OR

I have agreed to let certain individual(s) participate in discussion and decisions related to my medical care. Therefore, I hereby give permission for Carolina Oncology Specialists, PA and staff to disclose my personal information (in person, by telephone, by fax and/or by mail)` to the following individual(s):

***Primary Contact:** _____ ***Relationship:** _____

***Phone:** _____

Additional Names	Relationship	Phone

☐ Please list any conditions of disclosure:_____

I give authorization for Carolina Oncology Specialists, PA to communicate with me regarding my Private Health Information in the following manner (please check the item(s) that apply):

Leave message on my home voicemail/cell phone	Yes☐	No☐
Send Message via Text Message	Yes☐	No☐
Email (non-encrypted)	Yes☐	No☐

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature:_____ **Date:**_____

Living Will & Power of Attorney

Do you have a living will? Yes☐ No☐ **If yes, please provide a copy for our file.**

Medical Power of Attorney to make medical decisions on your behalf? Yes☐ No☐

If yes, please provide a copy for our file. Also, please provide their information below:

Carolina Oncology Specialists

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Patient Name: _____

Date of Birth: _____

FINANCIAL RESPONSIBILITY FORM

Agreement

Financial Responsibility

Please read each line below and sign the page to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

For patients with no insurance coverage, payment is due at the time of service. As a self-paying patient you will receive a discounted rate on your visits as long as payment is made in full on the date of service. If other arrangements are agreed upon, full charges are applicable. We accept cash, checks, and all other major credit cards.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

It is the patient's responsibility to notify us of any changes in insurance, mailing address, or contact information.

Your signature below signifies that you have read each item and understand your responsibility to this office as well as our responsibility to you and your care.

Patient Signature_____**Date:** _____

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Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

Date of Appointment _____/_____/_____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment

PAST MEDICAL HISTORY (please check any medical problems that you have had in the past)

CANCER HISTORY

- ☐ Bladder cancer
- ☐ Bone cancer
- ☐ Brain cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Esophageal cancer
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Small intestine cancer
- ☐ Stomach cancer
- ☐ Uterine cancer
- ☐ Other (list) _____

MEDICAL HISTORY

- ☐ Allergies
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Breast problems
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Cirrhosis
- ☐ Clotting disorder
- ☐ Congestive heart failure
- ☐ COPD (lung disease)
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Fibrocystic breast
- ☐ GERD (heartburn)
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ HIV/AIDS
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Myocardial infarction (heart attack)
- ☐ Nerve/muscle disease
- ☐ Osteoporosis
- ☐ Polycythemia vera
- ☐ Polymyalgia rheumatic
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ TIA (transient ischemic attack)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (specify)_____

SURGICAL HISTORY

- ☐ Appendectomy
- ☐ Arterial bypass
- ☐ Back Surgery
- ☐ Biopsy
- ☐ Cholecystectomy (gall bladder)
- ☐ Other (list)_____
- ☐ Hysterectomy
- ☐ Splenectomy

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Healthcare Power of Attorney (POA)? ☐ Yes ☐ No

If Yes, Name of POA_____

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

FAMILY HISTORY

Check below to report problems your family members have had. Please state the age when they had the problem if you know.

☐ I was adopted and my family medical history has not been disclosed to me

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia problems							
Bleeding disorder							
Blood count disorder							
Cancer- breast							
Cancer- colon							
Cancer- leukemia							
Cancer- lung							
Cancer- lymphoma							
Cancer- melanoma (skin)							
Cancer- multiple myeloma							
Cancer- ovarian							
Cancer- sarcoma							
Cancer- other (specify)							
Clotting disorder							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Stroke							
Other (specify)							
Alive and Age (Yes, No, n/a)							

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

IMMUNIZATIONS: Please indicate any immunizations you were given by listing the estimated month and year it was administered.

Covid ____/_____ Influenza ____/_____ Pneumonia ____/_____

RSV ____/_____ Shingles ____/_____ HPV (genital warts) ____/_____

REVIEW OF SYSTEMS (please circle any ***current*** problems you have on the list below)

General
Fatigue / Weakness
Restless Sleep
Daytime Drowsiness
Unhappiness
Depression / Sadness
Feeling "Blue" or "Hopeless for more than 2 weeks
Lack of Motivation
Excessive Irritability
Feelings of Worthlessness
Nervous / Anxiety
Unexplained Fever >100°
Frequent Night Sweats
Unexplained Weight Loss
Unexplained Weight Gain
Excessive Thirst

Skin
Changes in Moles
Rash / Skin Spots / Growth
Bruise Easily
Itching
Excessive Hair Growth
Hair Loss

Ears/Nose/Throat
Allergy Symptoms
Hearing Loss
Ringing in Ears
Dizziness / Dizzy Spells
Nose Bleeds
Sinus Problems
Hoarseness

Eyes
Eye Pain
Double Vision
Change in Vision
Itchy / Watery Eyes

Lungs
Cough / Wheeze
Snoring/ Gasping
Difficulty Breathing
Positive TB Skin Test

Heart
Chest Pain / Pressure
Exercise Intolerance
Heart Mumur
Palpitations
Irregular Pulse
Fainting Spells
Swollen Ankles
Leg Pain with Walking

Gastrointestinal
Heartburn / GERD
Change in Bowel Habits
Difficulty Swallowing
Abdominal Pain
Nausea / Vomiting
Diarrhea / Constipation
Bloody / Black Stools
Frequent Laxative Use

Musculoskeletal
Muscle / Joint Pain
Joint Swelling
Chronic Back Pain
Gout

Genitourinary
Frequent Urine Infections
Painful Urination
Frequent Urination
Urinary Leakage / Incontinence
Blood in Urine
Overnight Urination> 2 trips
Sexual Function Problems

Male
Decrease in Force Urination
Erection Problems
Testicle Lumps / Swelling

Female
Vaginal Discharge / Itching
History of Abnormal Pap Smear
Pain / Bleeding During Intercourse
Significant Menstrual Cramps
Hot Flashes / Night Sweats

Menstrual History
Age of onset_____ or Menopause
Reg or Irreg cycle
Flow: light / moderate / heavy
Length of cycle: Days of flow_____
# of pregnancies_____/ births _____
# of miscarriages / abortions _____

Breast
Pain / Lumps / Discharge

Neurological
Frequent Headaches
Numbness / Tingling
Memory Loss
Tremor / Shaking

Explanation:_____

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

ROUTINE CANCER SCREENING TESTS (list date of last test)

TEST	DATE OF LAST	TEST	DATE OF LAST
Mammogram		Prostate Exam	
Breast Exam		Prostate PSA	
Pap Smear/Pelvic Exam		Chest X-Ray	
Stool for Occult Blood		Colonoscopy	

SOCIAL HISTORY

Tobacco Use

(please check one)

☐ I have never smoked

☐ I have smoked, but rarely
When was the last time? _____

☐ I have quit smoking. Quit Date_____
How many packs/day? _____ # years_____

☐ I currently smoke _____ packs/day
years? _____

Other Tobacco:
☐ pipe ☐ cigar ☐ snuff ☐ chew ☐ vape
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

Average # of drinks/week:

5 oz. wine _____
12 oz. beer _____
1.5 oz. liquor _____
Is alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use recreational drugs? ☐ Yes ☐ No
Have you ever used needles? ☐ Yes ☐ No
Do you currently use marijuana? ☐Yes ☐No

Sexual History

Are you sexually active? ☐ Yes ☐ No
Current sexual partners(s): ☐ male ☐ female
Birth control method _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No
How often? ☐ Daily ☐ 4-6 times/week ☐ 1-3 times/week ☐ less than one time a week

What form of exercise? (ie: walking, jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Are you currently in a relationship? ☐ Yes ☐ No
If yes, do you feel safe in this relationship? ☐ Yes ☐ No
Any other concerns? _____

Social Demographics

Marital Status: ☐ single ☐ engaged ☐ living w/partner
☐ married ☐ separated ☐ divorced ☐ widowed

Occupation_____
Education completed ☐ grade school ☐ high school ☐ college ☐ graduate school
Number of children _____ Who lives with you?_____
Frequent foreign travel? ☐ Yes ☐ No Where? _____

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Medication List

Today's Date: _____ Preferred Pharmacy: _____ Telephone Number: _____

Do you have any known **drug** allergies? _____ Yes _____ No

If yes, please list:

Name of Drug Allergy	Reaction

Do you have any other allergies? (foods, dyes, environmental, bee stings, etc.) _____ Yes _____ No

If yes, please list:

Name of Other Allergy	Reaction

Please list all medications you are currently taking (include, prescription, over-the-counter, vaccines, herbals, vitamins, minerals, and diet supplement products).

Medication	Dose	Route	Frequency	Reason for Taking	Date Started	Prescriber

**** Please inform us of any medication changes throughout your care. ****

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Patient Name: _____

Date of Birth: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release medical information to include history, physical, pathology reports and radiological reports.

Please send information from:

_____

_____

_____

_____

_____

Please send to our office by fax at the following number:

828.324.4154

- **The intent of requesting these medical records is for my treatment. I understand I may revoke authorization by written request. I also understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.**

Patient Signature: _____ Date: _____

- **This authorization expires only if, and when revoked by person signing.**

CAROLINA ONCOLOGY SPECIALISTS, PA *2406 Century Place SE, Hickory, NC 28602*