Cancer Center at Wise Health System

Name:

PATIENT SUMMARY

Patient Overview

Nickname	
Birthdate	
Gender	
Race and Ethnicity	
Preferred language	
Spoken languages	
Read languages	
Primary care physician	
Referring physician	

Spouse Information

Marital Status	
Spouse	
Birthdate	

Patient Contact Information & Preferences

Address			
Home phone			
Work phone			
Cell phone			
Email:			
Phone messages ok?	Home?	Work?	Mobile?
Medical records access allowed to	Name: Relation: Phone:		
Emergency contacts	Name: Relation: Phone:		

Primary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Secondary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Tertiary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Preferred Pharmacy

Name	
Address	
Phone	

Living Will & Power of Attorney

Have a living will?	
Medical Power of Attorney to make medical decisions on your behalf?	Name: Relation: Phone:

Name:

INFORMED CONSENT

Agreement

RELEASE OF INFORMATION:

I authorize Choice Cancer Care to disclose my health information for the purpose of continued care, claims processing or other related needs. I authorize The Center to obtain health records from other providers as needed for my continued care. Any other use of this information requires written consent.

CONSENT TO TREATMENT:

I voluntarily consent to receive medical and health care services at Choice Cancer Care provided by physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures (such as lab and x-rays), examinations, and treatment that may include chemotherapy and/or radiation therapy.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare, Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to Choice Cancer Care. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to Choice Cancer Care. I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by Choice Cancer Care.

I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct and that it is my responsibility to notify Choice Cancer Care of changes to my address, telephone number, primary care physician, or insurance carrier.

I (do) consent to photographs or other audiovisual recordings related to my health record.

I understand that no warranty or guarantee has been made to me as to result or cure. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

Signature

I agree to the above.

Signature	

Name:

PRIVACY PRACTICES

Agreement

At Choice Cancer Care, we believe your health information is personal. We keep records of the care and services received at our clinics. We are committed to respect of your privacy. We are also required by law to maintain your confidentiality. This Notice describes the privacy practices of Choice Cancer Care. It applies to all of the health records that identify you and the care you receive with us. We are required by law to give you this Notice and to follow the terms of the Notice currently in effect. What are the duties of Choice Cancer Care concerning the use and disclosure of your health information?

We are required to:
• Maintain the privacy of your health information
• Abide by the terms of this notice
• Revise the Notice as indicated
• Post and make this Notice and any revisions available to you

*What information may we disclose without your permission? *

l. We use and disclose health information for treatment, payment, health care operations and other special circumstances.

For Treatment - We may use your health information to provide, coordinate, or manage your care and related services. This may mean disclosure to other health care providers, students involved in health care services training, home care providers, or pharmacies. For example, a doctor within our practice may share your health information with another doctor within our practice, or with a doctor at another health care institution (such as a hospital), to determine how to diagnose or treat you.

For Payment - We may disclose your health information so that the care received may be billed and paid for by you, your insurance company, or other third party. For example, we may tell your health plan about treatment planned so we can get prior approval or learn if your plan will pay for the treatment.

For Health Care Operations - We may use your health information to run our administrative, educational, and business functions and ensure and improve quality and safety. For example, we may use your health information to evaluate the performance of our physicians or staff in caring for you, or to educate our physicians or staff on how to improve the care they provide for you.

Special Circumstances - We may disclose limited health information for the following reasons: appointment reminders, follow-up on tests, or contacts for treatment alternatives or products and services that may benefit you.

2. Additional reasons Choice Cancer Care may be allowed or required to use your health information without your permission.
• As required by law
• Public health risks
• Healthcare oversight activities
• Law enforcement, lawsuits or disputes
• Suspected abuse or neglect
• Coroners, medical examiners, and funeral directors
• Organ and tissue donation
• Research
• Serious threat to health or safety to you or the public
• National security
• Military and veterans
• Workers' Compensation
• Correctional institutions

Name:

*What are your rights regarding your health information? *
Right to Request Restrictions on certain uses and disclosures of your information. Choice Cancer Care is not required to agree to a requested restriction, but will make every effort to accommodate reasonable requests.

Right to Receive Confidential Communications of protected health information.

Right to a Paper Copy of this Notice regardless if you have agreed to receive the Notice electronically.

Right of Access to Inspect and Copy your health record. Requests should be in writing. We may provide a summary of your health record. We will respond to your request in writing no more than 60 days from your request. Choice Cancer Care may charge a reasonable fee to cover costs.

Right to Amend your health record. Requests for changes must be in writing. We will respond to your request in writing no more than 60 days from the time of your request.

Right to an Accounting of disclosures of your health information, except for disclosures for treatment, payment and health care operations, disclosures for public health purposes or as required by law, and disclosures authorized by you. If you make more than one request in a 12-month period, Choice Cancer Care may charge a reasonable fee to cover costs.

Right to Request Confidential Communications of your health information by alternative means or at alternative locations. For example, you may instruct us to only send appointment messages by mail, with no phone messages.

Right to Revoke Authorization to use or disclose health information except to the extent that action has already been taken.

Revocations must be in writing.
*Who do I contact for questions, complaints or requests in writing? *

Choice Cancer Care
Office of Quality and Compliance
7301 N State Hwy 161, Suite 141
Irving, TX 75039
214-379-2700

You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. The contact information for the United States Department of Health and Human Services is:
Region VI, Office for Civil Rights

U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
214-767-4056

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Signature

You agree to the terms above.

Signature	

Cancer Center at Wise Health System

Name:

FINANCIAL RESPONSIBILITY

Agreement

You have furnished Choice Cancer Care with specific insurance information. We will verify your benefits. If the information you provided us differs from what we obtain, you could be responsible for any services rendered. If your insurance requires a referral, we will do our best to obtain those referrals from your Primary Care Physician (PCP), but ultimately the responsibility belongs to you, the patient.

Please be advised that it is your responsibility as the patient to notify us of changes in home address/telephone number, Primary Care Physician or Insurance Carrier.

Signature

I agree to the terms above.

Signature	

Cancer Center at Wise Health System

Name:

MEDICAL HISTORY REPORT

Patient Overview

Nickname	
Birthdate	
Gender	
Race and Ethnicity	
Preferred language	
Spoken languages	
Read languages	
Marital Status	
Primary care physician	
Referring Physician	
Other care provider	
Other care provider	

Employment

Employer	
Employer Address	
Employer Phone	
Occupation 1	
Dates	From: To:
Occupation 2	
Dates	From: To:
Military service	From: To:

Tests & Procedures

Test	Date	Abnormal	Results/Notes
Monthly self-breast exam			
Last mammogram (female)			
Last PAP smear (female)			
Last PSA test (male)			
Last colonoscopy or sigmoidoscopy			
Last prostate exam (male)			
Last bone density scan			
Biopsy			

Cancer Center at Wise Health System

Name:

Immunizations

Type	Date	Comments

Cancer & Blood Disorder History

Have you ever been diagnosed with cancer or a blood disorder? Circle one: Yes / No

Diagnosis	Date	Doctor	Chemo	RT	Sur	Alt	Additional Comments

Other Diagnoses & Medical Conditions

Diagnosis	Date	Comments

Past Surgeries & Hospitalizations

Have you ever been hospitalized or had any surgeries? Circle one: Yes / No

Surgeries

Type of Surgery:	Date	Hospital/Doc/Notes:

Hospitalizations

When	Where	Reason

Cancer Center at Wise Health System

Name:

Medications

Are you currently taking any prescriptions, over-the-counter medications, or alternative medications on a regular basis? Circle one: Yes / No

Medication	Frequency	Dosage	Started on	Stopped on

Allergies

Have you ever had an adverse reaction to IV dye used for X-ray studies? Yes / No

In the event that it becomes necessary, are you willing to accept blood or blood products? Yes / No

Do you have any allergies? Circle one: Yes / No

Allergic to	Reaction

Cancer Center at Wise Health System

Name:

Female History

Menstrual Period History

Age at first menstrual period	
Last menstrual period	
Reason period stopped	
Notes	

Pregnancy History

Ever been pregnant	
Number of pregnancies	
Number of births	
Age at first birth	
Age at last birth	
Notes	
Currently pregnant	
Breastfed	
Could be pregnant	
Trying to get pregnant	

History of Hormone Use

Have you ever taken birth control hormones? (i.e. pill, patch, injection)

Have you ever taken medication to increase your chance of pregnancy?

Have you ever had Hormone Replacement Therapy (HRT)?

Have you ever had anti-hormonal therapy?

Cancer Center at Wise Health System

Name:

Family Health History

Are you adopted?	
Twin	

Immediate Family

Relation	Name	Status	Cancer	Other illness	Notes

Do you have any biological children?

Children

Gender	Name	Status	Cancer	Other illness	Notes

Have any of your blood relatives had cancer? (including aunts, uncles, and grandparents)? Circle one: Yes / No

Extended Family

Relation	Name	Status	Cancer	Other illness	Notes

Do you have any other additional comments regarding your family health history?

Social & Lifestyle

Tobacco Use	Ever used?	Frequency	Number of years	Stopped?
Cigarettes				
Cigars				
Pipe				
Chewing Tobacco				

Other Substance Use	Ever used?	What kind?	Frequency
Alcohol			
Caffeinated Beverages			
Recreational Drugs			

Cancer Center at Wise Health System

Name:

Assistance

Emotional Assistance

Have you ever seen a professional for help with emotional problems? Explain.

Professional Needs

At this time, do you feel you need help with any of the following areas?

	Coping
	Financial assistance
	Nutrition
	Social work
	Home assistance
	Insurance
	Transportation
	Other

Health Maintenance

Date of last family doctor visit	
Date of last dental exam	
Recent dermatologist visit	Circle One: Yes / No Date: Reason:
Exercise frequency	
Diet	Circle one: diabetic liquid regular vegetarian
Describe any assistance needed for daily activities	
Do you have transportation to your office appointments?	
Do you have family/friends to assist with your needs?	
Are you in an assisted-living environment? If so, which one?	
Do you live alone?	
Are you currently under hospice care? If so, which one?	
Religious beliefs you would like us to be aware of	

Cancer Center at Wise Health System

Name:

REVIEW OF SYSTEMS

General	Y	N
Fatigue		
Fever/chills		
Night sweats		
Weight gain		
Loss of appetite		
Unplanned weight loss		
Special diet		
Change in diet		
Diabetes: diet control		
Other related issues		
Pain		
Leg pain, walking		
Leg pain, resting		
Lungs & Breathing	**Y**	**N**
Coughing up blood		
Short of breath, resting		
Short of breath, walking		
Wheezing		
Other related issues		
Cough		
Heart, Blood & Circulation	**Y**	**N**
Chest Pain		
Palpitations		
Ankle/foot swelling		
Other related issues		
Bleeding problems		
Bruise easily		
Legs/arms swelling		
Hematology issues		
Digestive/Gastrointestinal	**Y**	**N**
Abdominal pain		
Constipation		
Rectal bleeding		
Diarrhea		
Heartburn		
Hemorrhoids		
Difficulty swallowing		
Vomiting blood		
Other related issues		
Nausea/Vomiting		
Yellow skin/jaundice		
Black stools		

Neurological	Y	N
Headache		
Numbness/tingling		
Fainting spells		
Dizziness		
Memory loss		
Seizures		
Other Related issues		
Musculoskeletal	**Y**	**N**
Muscle weakness		
Joint/back pain		
Bone pain		
Muscle pain		
Muscle cramps		
Other related issues		
Eyes	**Y**	**N**
Blurred vision		
Double vision		
Eye pain		
Other related issues		
Visual changes		
Ears	**Y**	**N**
Ringing in ears		
Ear pain		
Other related issues		
Mouth, Nose & Throat	**Y**	**N**
Sinus pain		
Nose bleeds		
Sore throat		
Hoarseness		
Mouth sores		
Other related issues		
Runny/stuffy nose		
Lymphatics	**Y**	**N**
Swollen glands in neck		
Groin/armpit swelling		
Endocrine	**Y**	**N**
Increased thirst		
Heat or cold intolerant		
Hot flashes		

Cancer Center at Wise Health System

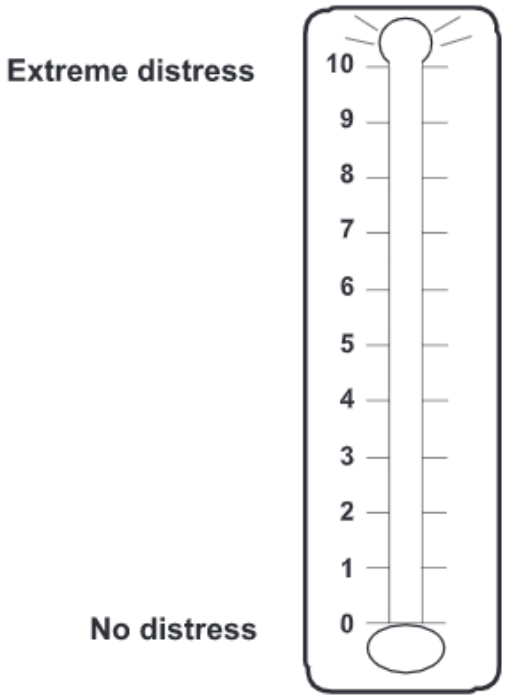
Name:

REVIEW OF SYSTEMS

Skin	Y	N
Open sores		
Change in moles/freckles		
Rashes/hives		
Dry skin		
Hair loss		
Other related issues		
Prone to sunburn		
Breast/Chest	**Y**	**N**
Breast Changes		
Lumps		
Nipple discharge		
Breast pain		
Other related issues		
Psychological	**Y**	**N**
Difficulty sleeping		
Mood swings		
Panic attacks		
Psychiatric problems		
Other related issues		
Depressed		
Agitated		
Urinary	**Y**	**N**
Blood in urine		
Burning		
Dribbling		
High frequency		
Urgency		
Loss of control		
Pain with urination		
Other related issues		
Men	**Y**	**N**
Impotence		
Trouble passing urine		
Women	**Y**	**N**
Vaginal dryness		
Vaginal discharge		
Abnormal vaginal bleeding		
Irregular menses		
Painful intercourse		

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.
Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING

0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐