The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

Patient Information Form

Welcome to West Cancer Center

We want to provide excellent service.
The following information will allow us to accurately handle your billing and insurance.

Date_____ **Referring Physician** First Last _____ **Primary Care Physician** First Last _____
(Referring and Primary Care physician may receive your medical records)

Please present Insurance Card and Photo ID

Patient Name _____ Date of Birth_____ /_____ /_____ SSN _____

❑ Male ❑ Female Marital Status: ❑ Married ❑ Widowed ❑ Single ❑ Divorced

Mailing Address _____ City _____ State_____ Zip_____

County _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone_____

Contact Preference ❑ Home ❑ Work ❑ Cell

Spouse/(Next of Kin) _____ Relationship _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Employer _____ Work Phone_____

Pharmacy _____ Phone _____

Pharmacy Cross Streets _____

Primary Insurance _____ Policy Holder _____ Policy Holder DOB _____

Secondary Insurance _____ Policy Holder _____ Policy Holder DOB _____

Information required by Federal Government

Race ❑ Caucasian/White ❑ African American/Black ❑ American Indian ❑ Asian ❑ Other

Ethnic Background ❑ Hispanic ❑ Non Hispanic **Preferred Language** _____

Internal Office Use Only

Verified by_____ MRN_____

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MEDICAL HISTORY FORM

PATIENT NAME: _____ **D.O.B.** _____

SURGICAL HISTORY:

Please list any previous surgeries you have had and when you had them:

SURGERY	WHEN?
_____	_____
_____	_____
_____	_____

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MEDICAL HISTORY:

Please list any medical problems you have and their duration:

PROBLEM	HOW LONG?
_____	_____
_____	_____
_____	_____

Have you ever been diagnosed with sleep apnea? ❑ YES ❑ NO

Are you allergic to latex? ❑ YES ❑ NO

Please list any Drug Allergies you have:_____

_____

CHECK SYMPTOMS YOU MAY HAVE:

- ❑ weight loss
- ❑ fever
- ❑ difficulty with eyes, ears, nose or throat
- ❑ chest pain
- ❑ shortness of breath
- ❑ cough
- ❑ nausea/vomiting
- ❑ sweats
- ❑ constipation/diarrhea
- ❑ blood in stool/black stool
- ❑ abnormal menstrual periods
- ❑ blood in urine
- ❑ difficulty with urination
- ❑ bone / joint pain
- ❑ vaginal problems
- ❑ skin rash / lumps
- ❑ fainting
- ❑ numbness / weakness
- ❑ sexual problems
- ❑ dizziness / blackout spells
- ❑ swollen glands

SOCIAL HISTORY:

1. Occupation: _____
2. Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed
3. Lives with _____ Transportation _____
4. Do you smoke? ❑ YES ❑ NO
   IF YES, estimate how many packs a day: _____
   IF YES, how many years have you smoked? _____
5. Are you a former smoker? ❑ YES ❑ NO
   IF YES, how many years did you smoke? _____
   IF YES, when did you quit smoking? _____
   IF YES, estimate how many packs per day? _____
6. Do you drink alcoholic beverages? ❑ YES ❑ NO
   IF YES, how many drinks do you have per week? _____
7. Do you have a history of recreational drug use? ❑ YES ❑ NO

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BREAST & REPRODUCTIVE HISTORY FORM (FEMALE)

PATIENT NAME: _____ D.O.B. _____

BREAST HISTORY:

1. ❑ YES ❑ NO Are you PREGNANT now, or is there a possibility that you could be pregnant?
2. ❑ YES ❑ NO Are you having any NEW breast problems NOW?

IF YES, please describe: Right Breast _____ Left Breast _____

Right Breast _____ Left Breast _____

3. ❑ YES ❑ NO Have you ever had a mammogram?

When?_____ Where? _____

When?_____ Where? _____

When?_____ Where? _____

4. ❑ YES ❑ NO Have you ever had a breast ultrasound?

When?_____ Where? _____

5. ❑ YES ❑ NO Do you have breast implants?
6. ❑ YES ❑ NO Do you perform monthly breast exams?
7. ❑ YES ❑ NO Have you ever had a breast biopsy (removal of a piece of breast tissue)?

IF YES, estimate how many: _____

IF YES, Were your results abnormal? _____

8. ❑ YES ❑ NO Have YOU ever had breast cancer?

IF YES, how old where you when you were diagnosed? _____

IF YES, what type of treatment did you receive?

❑ Surgery ❑ Chemotherapy ❑ Radiation

IF YES, who was your doctor? _____

GYNECOLOGIC HISTORY:

1. At what age did you have your first period? _____
2. How many times have you been pregnant? _____
3. How many children have you given birth to? _____
4. How old were you when you gave birth to your first child? _____
5. ❑ YES ❑ NO Are you post menopausal (no longer having periods)?

IF YES, how old were you when you stopped having periods? _____

6. ❑ YES ❑ NO Have you had your uterus removed?
7. ❑ YES ❑ NO Have you had your ovaries removed?
8. ❑ YES ❑ NO Have you ever taken oral contraceptives for birth control?

IF YES, A) For how long? _____

B) ❑ YES ❑ NO Are you currently still taking them?

9. ❑ YES ❑ NO Have you ever taken hormone replacement therapy? (Estrogen or Progesterone)

IF YES, A) For how long? _____

B) ❑ YES ❑ NO Are you currently still taking them?

C) If you are not taking any longer, how long have you been off? _____

D) ❑ YES ❑ NO Do you currently have any hot flashes or night sweats?

Are they? ❑ Mild ❑ Moderate ❑ Severe

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Personal / Family Medical History Form

Name: _____

1. What is your ancestry: (English, German, African, etc.) _____
   Are you of Eastern European Jewish Ancestry? ❑ YES ❑ NO
2. Do you have any relatives with cancer? ❑ YES ❑ NO
   (If yes, please fill in as much information in the table below as possible.)
3. Would you be interested in speaking with someone about your history of cancer? ❑ YES ❑ NO

	Other Chronic Disease or Conditions	Cancer Site (ex. Breast, Lung, Colon)	Age Detected	Living (L) or Deceased (D)	Current Age or Age at Death
Self Age:					
Mother					
Father					
Sister(s) _____ _____					
Brother(s) _____ _____					
Children _____ _____					
Grandfather (maternal)					
Grandmother (maternal)					
Grandfather (paternal)					
Grandmother (paternal)					
Aunts/Uncles(maternal) _____ _____					
Aunts/Uncles (paternal) _____ _____					
First cousins (maternal) _____ _____					
First cousins (paternal) _____ _____					

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Risk Assessment for Hereditary Cancer Syndromes

Patient Name:_____

Date of Birth: _____ Date Completed:_____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Self Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

			SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast Cancer at age 50 or younger			
Y	N	Breast Cancer over the age of 50			
Y	N	Bilateral Breast Cancer or Breast Cancer twice in the same person			
Y	N	Ovarian Cancer			
Y	N	Male Breast Cancer			
Y	N	"Triple negative Breast Cancer" under age 60			
Y	N	Two or more relatives with Breast Cancer, one under age 50			
Y	N	Three or more relatives with Breast Cancer at any age			
Y	N	Pancreatic Cancer and Breast Cancer in the same person or same side of the family			
Y	N	Ashkenazi Jewish ancestry and Breast or Ovarian Cancer on the same side of the family			
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 60			
Y	N	Two or more of the following cancers in the same person or on the same side of family: colorectal, uterine/endometrial, ovarian, stomach, small bowel, pancreas			
Y	N	10 or more lifetime colon polyps			
Y	N	Childhood Cancer			
Y	N	Diffuse type Gastric Cancer under age 50			
Y	N	*Sarcoma under age 30*			
Y	N	*Thyroid under age 40*			
Y	N	Other Cancers If yes, please explain: _____			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer?			

FOR OFFICE USE ONLY

❑ Candidate for further risk assessment and/or genetic testing
❑ Information given to patient to review
❑ Follow-up appointment scheduled Date: _____

❑ Patient offered genetic testing:
❑ Accepted
❑ Declined

_____ _____
Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer please ask your healthcare provider.

MEDICATION LOG

Patient Name: _____

It is important to have a complete record of your current medications. This list will include over the counter medications, the dosage, how it is taken (scheduled), and the doctor who prescribed this for you.

Medication	Dose	Schedule (How taken)	Doctor who prescribed

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PATIENT REPRESENTATIVE IDENTIFICATION FORM

PATIENT NAME _____ **DOB** _____

(Office use only) **CHART #** _____

By law, the HIPAA Privacy Rule Prohibits West Cancer Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. This Rule became effective April 14, 2003.

1) Please list the names of all persons that you wish to have access to your Protected Health Information (PHI) (i.e. those making appointments or checking on test results for you):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

2) Please list the name of the person(s) with whom we can discuss your bill:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

3) If applicable, please list the name of your Legal Representative:

Name: _____ Relationship to Patient: _____

Check one: By what authority is this person your Legal Representative?

❑ Next of Kin ❑ Guardian ❑ General Power of Attorney ❑ Health Care Power of Attorney

PLEASE NOTE: In order for us to disclose your Private Health Information, the above representatives must be able to provide two (2) of the three (3) identifiers listed below:

- Patient's social security number
- Patient's date of birth; or
- Patient's zip code

Patient Signature: _____ Date: _____

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Financial Policy

Thank you for choosing West Cancer Center as your health care provider. We are committed to your visit being successful on all levels. Because healthcare reimbursement is a complex and sometimes complicated system, we would like to work with you to ensure insurance benefits and financial assistance are maximized.

If you have health insurance:

West Cancer Center accepts assignment of insurance benefits for Medicare, Medicaid, TennCare, MS CAN, Workers' Compensation and many Commercial health insurance plans. Your insurance policy is a contract between you and your insurance company. Please inform us of all health insurance carriers and if you have more than one, indicate which is primary and secondary. If your insurance coverage changes, please inform our office as soon as possible so we can file your claims properly.

West Cancer Center will file a claim with your health insurance company for services you receive. The patient balance as determined by your policy is your responsibility and will be requested at the time of service. **If your insurance company has not paid within 120 days of the date of service, the balance will be transferred to you.**

As the patient, you are responsible for knowing your policy benefits, especially which outside lab to use, where pathology specimens should be sent and whether you can have radiology services in our office.

If you do not have health insurance:

If you do not have insurance coverage payment for services will be requested at the time services are rendered. Our policy is to reduce the usual and customary rates charged to uninsured patients to approximate the payment rates allowed by private insurance companies in the market. Please contact our Patient Representatives at (901) 683.0055 prior to your visit to discuss payment options.

I acknowledge receipt of West Cancer Center's Financial Policy and authorize West Cancer Center to release to my health insurance company or organizations that provide financial assistance, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to West Cancer Center.

Patient or Patient's Representative Signature: _____ Date: _____

Patient Privacy Notice

I acknowledge that West Cancer Center's Privacy Notice has been made available to me.

Patient or Patient Representative Signature: _____ Date: _____

Advanced Directive for Medical Care (Living Will)

Do you have a Living Will? Yes No

Did you bring a copy with you? Yes No

I acknowledge that if I have a Living Will or any form of Advanced Directives I should inform the clinic and present a copy, even if one is created after my initiation of care.

Patient or Patient's Representative Signature: _____ Date: _____

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WEST CANCER CENTER

Authorization for West Cancer Center to obtain Your medical records from other care providers

"Patient, please complete and sign this form so we can request your records from other providers"

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I,_____, Date of Birth_____do hereby authorize West Cancer Center to obtain, use, disclose or receive my individually identifiable health information as described below :

FROM: Any of my healthcare providers or institutions containing records pertinent to my care

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE CHOOSE AND INITIAL A OR B

X **A** **Complete medical record** which may contain treatment notes regarding radiology, pathology ***(including HIV test results and genetic testing information),*** immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2,*** and other common medical record documentation by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

_____ **B** For information collected/services described below and provided **during the time period of :** _____

_____

Description of records to be released: _____

_____

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

Release my records to

ATTN: West Cancer Center

For the purpose(s) of: Treatment, Payments or Operations

I understand that I may withdraw my authorization in writing to West Cancer Center at any time, except to the extent that action has been taken in reliance on this statement. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to West Cancer Center. If this authorization has not been revoked, and if I have not indicated an expiration date, this authorization will expire one year from the date of execution.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST**
- **I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY**

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative _____

Description of the Representative's authority to act in behalf of the patient _____

Relationship to the patient: _____

*For information about how your medical information may be used or disclosed, please see the Patient Notice.