The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

Patient Information Form

Welcome to the Department of Radiation Oncology

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_____

The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

PATIENT INTAKE QUESTIONNAIRE

Methodist Radiation Oncology

As a courtesy to your physicians we will send each a copy of your consultation.
List each of the physicians you see on a regular basis:

_____

_____

Chief Complaint: (Please explain the reason you are here today): _____

PAST MEDICAL HISTORY:

Prior cancers: Yes___ No___ Prior radiation: Yes___ No___

Prior chemotherapy: Yes___ No___ Pacemaker: Yes___ No___

PAST SURGERIES: None _____

List any surgeries (including surgery for this cancer diagnosis, if applicable) and date performed.

1._____

2._____

3._____

4._____

5._____

PAST ILLNESSES:

	YES		YES		YES
Anemia		Heart Attack		Parkinson's Disease	
Angina		Heart Failure		Psychiatric Treatment	
Arthritis		Heart Murmur		Rheumatoid Arthritis	
Blood Clots		Hepatic or Liver Disease		Scleroderma	
Chronic Bronchitis		Hiatal Hernia		Seizures or Epilepsy	
Colitis		High Blood Pressure		Severe Anxiety	
Crohn's Disease		Human Immune Virus (HIV)		Skin Condition(s)	
Cystic or Bladder Infections		Irregular Heartbeat		Stroke or Paralysis	
Depression		Kidney Failure		Thyroid Disease or Goiter	
Diabetes or Sugar		Kidney Stones		Tuberculosis (TB)	
Diverticular Disease/Polyps		Lupus		Ulcers of Stomach or Duodenum	
Emphysema		Multiple Sclerosis		NONE OF THE ABOVE	
Gall Bladder Disease		Other Collagen Vascular Disease			
GYN Problems or Infections		Pancreatitis			

ALLERGIES: List all allergies and reactions.

1._____

2._____

3._____

REVIEW OF SYSTEMS:
Please √ any of the items that apply to you or that you may be experiencing. You may write any explanation you feel is pertinent next to the appropriate symptom. Example: Fatigue-since surgery, etc.

SOCIAL HISTORY:
Occupation:
Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed
Lives with _____ Transportation _____
Do you smoke? ❑ YES ❑ NO
IF YES, estimate how many packs a day: _____
IF YES, how many years have you smoked? _____
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? _____
Do you drink alcoholic beverages? ❑ YES ❑ NO
IF YES, how many drinks do you have per week? _____
Do you have a history of recreational drug use? ❑ YES ❑ NO

GENERAL:
Normal Weight: _____ ❑ Recent Weight Loss Amt: _____ ❑ Recent Weight Gain- Amt: _____
❑ Loss of Appetite ❑ Fatigue ❑ Weakness ❑ Fevers ❑ Chills ❑ Night Sweats

EYES:
❑ Glaucoma ❑ Cataracts ❑ Double vision ❑ Change in vision ❑ Other vision problems

EARS / NOSE / THROAT:
❑ Loss of hearing ❑ Nose Bleed ❑ Sore throat ❑ Difficulty swallowing
❑ Ringing in ear(s) ❑ Hoarseness ❑ Dentures ❑ Pain upon swallowing
❑ Earache ❑ Dry mouth ❑ Dental problems ❑ Loss of taste

CARDIOVASCULAR:
❑ Pacemaker ❑ Irregular heartbeat ❑ Difficulty swallowing ❑ Short of breath when lying down
❑ Chest pain ❑ Fainting spells ❑ Oxygen use at home

RESPIRATORY:
❑ Shortness of breath ❑ Dry cough ❑ Coughing up sputum ❑ Coughing up blood

GASTROINTESTINAL:
❑ Heartburn ❑ Jaundice ❑ Diarrhea ❑ Hemorrhoids / fissures ❑ Nausea or vomiting
❑ Constipation ❑ Blood in stool ❑ Recent change in bowel movements ❑ Abdominal pain
How often do you have a bowel movement? _____

GENITOURINARY:
❑ Difficulty urinating ❑ Color change of urine ❑ Painful urination
❑ Up at night to pass urine ❑ Sexual difficulties ❑ Blood in urine
How often do you urinate: during the day? _____ during the night? _____

WOMEN ONLY:
❑ Menopause ❑ Hot flashes ❑ Hormone therapy ❑ Currently sexually active
Date of last menstrual period: _____ Number of pregnancies: _____ Number of live births: _____

MEN ONLY:
❑ Currently sexually active ❑ Penile discharge ❑ Testicular pain ❑ Difficulty with erections ❑ Testicular mass

MUSCULOSKELETAL:
❑ Leg cramps ❑ Painful muscles ❑ Painful joints ❑ Artificial joints

SKIN & BREASTS:
❑ Itching ❑ Pain in breast ❑ Discharge or bleeding from nipple
❑ Rash ❑ Nipple inversion ❑ Change in size, shape or contour of breast
❑ Color changes ❑ Change in nipple ❑ Lump or mass in breast or armpit

NEUROLOGICAL:
❑ Headaches ❑ Difficulty with words ❑ Loss of consciousness
❑ Tremors ❑ Dizziness ❑ Difficulty with balance
❑ Memory Loss ❑ Seizures ❑ Numbness or tingling

PSYCHIATRIC:
❑ Nervousness ❑ Depression ❑ Anxiety ❑ Change in personality

HEMATOLOGIC & LYMPHATIC:
❑ Swollen lymph glands ❑ Excessive bruising ❑ Excessive bleeding

ENDOCRINE:
❑ Excessive thirst ❑ Excessive urination

Do you have any other health information that you wish to share? _____

The University of Tennessee
WEST Cancer Center
Methodist Healthcare Family

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) _____ _____					

The University of Tennessee
WEST Cancer Center
Methodist Healthcare Family

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

The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

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: _____

The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

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 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: _____

The University of Tennessee
WEST Cancer Center
Methodist Healthcare Family

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.