PATIENT DEMOGRAPHICS

PATIENT INFORMATION

DATE:	PATIENT MR# (OFFICE USE ONLY)

PATIENT NAME: LAST FIRST MI

HOME ADDRESS	CITY:	STATE:	ZIP:

SEX: ☐ MALE ☐ FEMALE

HOME PHONE:	CELL PHONE:	WORK PHONE:

PREFERRED METHOD OF CONTACT: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE
☐ HOME MAIL ☐ WORK MAIL ☐ EMAIL ______________________@________________

DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE: ☐ CAUCASIAN / WHITE ☐ AFRICAN AMERICAN / BLACK ☐ASIAN ☐ HISPANIC ☐ AMERICAN INDIAN ☐ OTHER: ___________

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

LANGUAGE PREFERENCE: ☐ ENGLISH ☐ SPANISH ☐ CHINESE ☐ FRENCH ☐ GERMAN ☐ HINDI
☐ ITALIAN ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ SIGN LANGUAGE

EMPLOYER:____

WORK ADDRESS:____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ NOT EMPLOYED ☐ RETIRED (DATE)__________

SPOUSE INFORMATION

SPOUSE NAME: LAST FIRST MI

DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

EMPLOYER:____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ NOT EMPLOYED ☐ RETIRED (DATE)__________

REFERRING PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN:	TELEPHONE:
ADDRESS:	
REFERRING PHYSICIAN: (If different than primary care)	TELEPHONE:
ADDRESS:	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	PHONE #:
NAME OF POLICY HOLDER:	POLICY#:
EFFECTIVE DATE OF COVERAGE:	GROUP NAME/NUMBER:
SECONDARY INSURANCE CO (if applicable):	PHONE #:
NAME OF POLICY HOLDER:	POLICY #:
EFFECTIVE DATE OF COVERAGE:	GROUP NAME/NUMBER:
DO YOU HAVE A CANCER POLICY? ☐ YES ☐ NO	IF YES, NAME OF INSURANCE COMPANY: POLICY #:

I certify that all of the information provided is complete and accurate. I understand that it is my responsibility to notify Radiation Oncology Services, Inc. and its Affiliates of any changes in my health care coverage. If a change in my health care coverage is not reported, I understand that I may be financially responsible if payment is denied.

Patient Signature: ________________________________ **Date:** ____________

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Cobb Center for Radiation Therapy, Inc.

Radiation Oncology Services, Inc., and Affiliates

Newnan Regional Radiation Therapy Center, Inc.
Griffin Regional Radiation Therapy Center, Inc.
Henry Radiation Oncology Center, LLC

NEW PATIENT HISTORY QUESTIONNAIRE

Patient Name:	Preferred Nickname:			
	Work Phone			
	Home Phone		Age	

Please answer the following questions to help us evaluate your medical problems. This is a review of your personal medical history. Our nurse will review this form with you after you have completed it.

I have seen the following specialists:

❑ Radiation Oncology ❑ Medical Oncology ❑ Surgical Oncology

Other: ______________________________

Chief Complaint (please explain why you are here today):

____
____
____
____
____

PAST HISTORY (Check √ if YES

	YES		YES		YES
Anemia		GYN Problems/Infections		Prostate Disease	
Angina		Heart Attack		Pancreatitis	
Arthritis		Heart Disease/Murmur		Parkinson's Disease	
Asthma		Hepatic (liver) Disease		Psychiatric Treatment	
Blood Clots		Hiatal Hernia		Rheumatoid Arthritis	
Chronic Bronchitis		High Blood Pressure		Scleroderma	
Colitis		Human Immune Virus (HIV)		Seizures or Epilepsy	
Crohn's Disease		Irregular Heart Beat		Severe Anxiety	
Cystitis (bladder infection)		Kidney disease/Stones		Skin Condition(s)	
Depression		Kidney Infection/Bleeding		Stroke or Paralysis	
Diabetes		Lupus		Thyroid Disease or Goiter	
Diverticular Disease/Polyps		Multiple Sclerosis		Tuberculosis	
Emphysema		Other Collagen Vascular Disease		Ulcers	
Gallbladder Disease					
Glaucoma/Cataracts					

List any other illnesses, medical problems or past surgery experienced.

FAMILY HISTORY

Mother	❑ Alive	❑ Deceased	Cause:		Age	
Father	❑ Alive	❑ Deceased	Cause:		Age	

Patient Name: ____

FAMILY HISTORY OF CANCER

IMMEDIATE		Type of Cancer	MATERNAL		Type of Cancer	PATERNAL		Type of Cancer
Mother	❑ Yes		Grandmother	❑ Yes		Grandmother	❑ Yes	
Father	❑ Yes		Grandfather	❑ Yes		Grandfather	❑ Yes	
Sister	❑ Yes		Aunt	❑ Yes		Aunt	❑ Yes	
Brother	❑ Yes		Uncle	❑ Yes		Uncle	❑ Yes	
	❑ Yes			❑ Yes			❑ Yes	

SOCIAL HISTORY

Present Occupation: ____________________ ***Past Occupation:*** ________________

Has your illness forced you to stop working or change your hours? ❑ Yes ❑ No

Education: ❑ Completed High School ❑ Completed College ❑ Other: ______________

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widow(ed)

Name of spouse or significant other: __________________ Relationship to patient:________

May we discuss your care with your principle care person? ❑ Yes ❑ No

Does principle care person live with you? ❑ Yes ❑ No

Health of principle care person: ______________________

Is this person willing to help you? ❑ Yes ❑ No

Children: Number Living: ________________ Number Deceased: ____________________

CURRENT LIVING CONDITIONS

❑ Live Alone ❑ House ❑ Nursing/Personal Care Home ❑ Assisted Living

❑ Live with family/others ❑ Visiting Nurse ❑ Apartment

SOCIO-ECONOMIC

	Explain:
Do you have transportation problems?	
Do you have a religious preference? (optional)	
Do you have any special requirements?	
Do you have disabilities we should know about?	
Do you have any financial or home care needs?	

ADVANCE DIRECTIVE

Do you have: *(If yes, please bring a copy for your chart.)*

- Living Will ❑ Yes ❑ No If no, do you want information? ❑ Yes ❑ No
- Power of Attorney for Health Care ❑ Yes ❑ No
- Power of Attorney for General Usage ❑ Yes ❑ No

HABITS

Ever used TOBACCO ❑ Yes ❑ No	Ever used ALCOHOL ❑ Yes ❑ No	DRUG DEPENDENCY ❑ Yes ❑ No
Type:	Type:	Type:
How much:	How much:	How much:
Started: Stopped	Started: Stopped	Started: Stopped

I verify the information in this questionnaire is true and correct to the best of my knowledge.

PATIENT SIGNATURE: ______________________________ **DATE:** __________

ASSIGNMENT OF INSURANCE BENEFITS/ RELEASE OF MEDICAL INFORMATION

PAYMENT OF INSURANCE BENEFITS

I authorize payment to **Radiation Oncology Services, Inc. and Affiliates** for medical services provided. I understand that I am responsible for amount not covered by insurance.

RELEASE OF MEDICAL INFORMATION

I authorize the release or the ability to retrieve certain demographic and clinical treatment information necessary for **Radiation Oncology Services, Inc. and Affiliates** to process insurance claims and to release this information to other medical providers as necessary for my medical care. This information may be transmitted either on paper or electronically. I understand that the information will be treated with strict confidence. Reasonable efforts will be used to maintain confidentiality and prevent disclosure of the information except on my behalf or as may be permitted or required by law.

____
Patient Signature Date

______________________ ______________________
Print Name Medical Record Number

____
Facility Witness Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ have received and
Patient's Name
reviewed a copy of the Notice of Privacy Practices.

Our goal is to assure privacy and deliver care in the safest possible manner. We follow all HIPAA guidelines. We use the methods outlined in our Notice of Privacy Practices for patient identification purposes or to communicate your protected health information.

Please indicate below any communication restrictions. **(Alternative methods of contact MUST BE GIVEN if you indicate any restrictions.)**

____

____

____

____

____

I authorize my Protected Health Information (PHI) may be released, if necessary, to the following person(s) including:

____
Name (Emergency Contact) Relationship Phone Number

____
Name Relationship Phone Number

____
Name Relationship Phone Number

I understand that if I should have any questions or concerns they are to be directed to either the Center Site Manager or the HIPAA Privacy Officer, at:
275 Professional Court, Suite A, Riverdale, GA 30274, 770.994.1650, ext. 1200

_______________________________ _______________
Signature of Patient or Legal Guardian **Date**

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RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS

I, ____ authorize
Patient's Name

Radiation Oncology Services, Inc., and Affiliates to release certain demographic and clinical treatment information to other medical providers as necessary for my medical care. I understand that the information being released may contain psychiatric, alcohol, drug and/or HIV/AIDS information included in, but not limited to, the history and physical/consult. *I understand that I will be asked to sign separate authorization forms before treatment records can be released for psychiatric disorders, mental illness, drug and alcohol abuse and HIV/AIDS.* This information may be transmitted either on paper or electronically. I understand that the information will be treated with strict confidence. Reasonable efforts will be used to maintain confidentiality and prevent disclosure of the information except on my behalf or as may be permitted or required by law.

____

Patient Signature **Date**

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Piedmont Fayette Cancer Center

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ePrescribing (eRX) Consent Form

ePrescribing is defined as the physician's ability to electronically send and receive accurate, error free, understandable prescription information directly from the point-of-care to a pharmacy. The Medicare Modernization Act (MMA) of 2003 listed standards relating to an *ePrescribe* (*eRX*) program. These include:

- **Formulary and Benefit Transactions**—gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication History Transactions**—Provides the physician with information about medications the patient is already taking in order to minimize adverse drug events.
- **Fill and Refill Status Notification**—Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, partially filled or when refills are needed.

By signing this consent form, you are authorizing us (**Radiation Oncology Services, Inc. and Affiliates**) to request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Additionally, you are authorizing us to electronically transmit and receive prescription information between our offices and the pharmacy of your choice.

Pharmacy Information

Pharmacy Name:_______________________________________ **Store #:**__________

Address:________________________ **City:**______________ **State:**____ **Zip:**________

Phone: _____________________________ **Fax:**_______________________________

___________________________________ ______________________________
Print Name Date

_____________________________________ ______________________________
Patient Signature Medical Record Number

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Revised 08/29/2011

PATIENT NAME: ____________________________________

PHYSICIAN WHO REFRERRED YOU TO US

NAME: ____
STREET ADDRESS:____
CITY, STATE, ZIP: ____
PHONE NUMBER: ____

OTHER PHYSICIANS YOU WOULD LIKE TO RECEIVE REPORTS FROM US

NAME: ____
STREET ADDRESS:____
CITY, STATE, ZIP: ____
PHONE NUMBER: ____

NAME: ____
STREET ADDRESS:____
CITY, STATE, ZIP: ____
PHONE NUMBER: ____

NAME: ____
STREET ADDRESS:____
CITY, STATE, ZIP: ____
PHONE NUMBER: ____

NAME: ____
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NAME: ____
STREET ADDRESS:____
CITY, STATE, ZIP: ____
PHONE NUMBER: ____