New/Updated Patient Demographic Information Form

DATE_____ SOCIAL SECURITY NUMBER_____

Title_____ Last Name_____ First Name_____ MI_____

Physical Address_____

Mailing Address (if Different) _____

Zip Code_____ City_____ County_____ Home Phone (_____) _____

Cell Number (_____) _____ Email Address_____

Birthday_____ Sex M or F Race_____ Marital Status M S D W Student Y N Employment Status F P N R

Physician_____

Referring Physician/Family Doctor_____

Employer & Insurance Information

Name/Place of Employment_____

Address_____ City_____ Zip Code_____

Phone Number_____ Extension_____ Fax Number_____

Primary Insurance Name_____ Cards Copied Y N

Secondary Insurance Name_____ Cards Copied Y N

If insurance is in spouse's name Complete the below

Name_____ Social Security Number_____

Date of Birth _____ Employer_____

In Case of Emergency

Name_____ Phone #1_____ Phone #2_____ Relationship_____

Name_____ Phone #1_____ Phone #2_____ Relationship_____

Name_____ Phone #1_____ Phone #2_____ Relationship_____

***My signature certifies the above information is correct_____

To be completed by Staff

EMR #_____ Scanned_____ Initials_____

PATIENT'S MEDICAL QUESTIONNAIRE (CONFIDENTIAL)	RADIATION SC ONCOLOGY

(PLEASE PRINT)

NAME:			DATE:
AGE:	SEX:	DATE OF BIRTH:	DAYTIME PHONE: (or cell)

REFERRING PHYSICIAN OR CHEMOTHERAPY DOCTOR:

WHAT KIND OF CANCER DO YOU HAVE? (Example: Lung, Colon, Breast, etc)

WHAT AREA IS TO BE RADIATED AT THIS TIME?

CURRENTLY RECEIVING CHEMOTHERAPY or WILL BE TAKING IT ALONG WITH RADIATION TREATMENTS? Y N

ANY PROBLEMS WITH CHEMOTHERAPY (PLEASE LIST)? Y N

ANY HISTORY OF CANCER IN A BLOOD RELATIVE? Y N

IF YES, LIST TYPE OF CANCER AND RELATIONSHIP OF FAMILY MEMBER:

MEDICINES: LIST ALL MEDICINES THAT YOU HAVE BEEN TAKING RECENTLY. INCLUDE ALL VITAMINS AND NON-PRESCRIPTION MEDICINES (OR SUPPLY A LIST)

MEDICATION NAMES	DOSE (mg) & TIMES PER DAY	MEDICATION NAMES	DOSE (mg) & TIMES PER DAY
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

ALLERGIES OR REACTIONS TO MEDICATIONS:

MEDICATION NAME:	REACTION:

CURRENT TOBACCO USE: Y N	PACKS PER DAY:	CIGARS, PIPE, ORAL TOBACCO: Y N (circle appropriate ones)

HOW MANY YEARS DID YOU SMOKE? (APPROXIMATELY)

IF YOU CURRENTLY SMOKE, HAVE YOU CONSIDERED QUITTING? Y N

CIRCLE ANY SYMPTOMS YOU CURRENTLY HAVE

RECENT **WEIGHT GAIN OR LOSS? (AMOUNT) _____LBS**	**Y N**
ANY FEVER, CHILLS, NIGHT SWEATS, LOSS OF APPETITE?	**Y N**
NEW, FREQUENT OR SEVERE HEADACHES?	**Y N**
FALLS, IMBALANCE, DIFFICULTY WALKING, TREMORS, WEAKNESS?	**Y N**
LOSS OF CONSCIOUSNESS, FAINTING OR SEIZURES?	**Y N**
LOSS OF MEMORY, CONFUSION, DEPRESSION, ANXIETY, ANGER?	**Y N**
DO YOU DRINK ALCOHOL? HOW MANY DRINKS PER DAY?	**Y N**
TROUBLE CHEWING OR SWALLOWING?	**Y N**
ANY PROBLEMS WITH VISION OR HEARING?	**Y N**
SHORT OF BREATH HURRYING OR WALKING UP STAIRS?	**Y N**
DISCOMFORT OR PAIN IN CHEST, COUGH OR INCREASED PHLEGM?	**Y N**
SWELLING OF THE ANKLES, SKIPPING HEARTBEAT, DIZZINESS?	**Y N**
PAIN OR TIREDNESS IN LEGS WHILE WALKING?	**Y N**
HIGH BLOOD PRESSURE? NUMBER OF YEARS? _____	**Y N**
FREQUENT HEARTBURN, INDIGESTION, NAUSEA OR VOMITING?	**Y N**
DIARRHEA, CONSTIPATION, RECTAL BLEEDING OR BLACK STOOLS?	**Y N**
SWOLLEN LYMPH NODES "GLANDS", BLEEDING GUMS?	**Y N**
DIFFICULTY URINATING ("PASSING WATER"), OR BLOOD IN URINE?	**Y N**
PAIN IN BACK, ARMS, LEGS OR MUSCLES?	**Y N**
ANY SKIN PROBLEMS – DRYNESS, ITCHING, RASH, SORES, BLEEDING?	**Y N**
ANY *ALLERGIES* TO FOOD, POLLEN, TAPE, CHEMICALS, ANIMALS?	**Y N**
APPROXIMATE DATE OF LAST PAP SMEAR:	
APPROXIMATE DATE OF LAST MAMMOGRAM:	

ARE YOU CURRENTLY HAVING PAIN? Y N												
IF YES, WHAT IS THE LOCATION?												
SEVERITY OF PAIN AT ITS *WORST*:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Higher number is more severe**
SEVERITY OF PAIN AT *PRESENT*:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Higher number is more severe**
WHAT PAIN TREATMENTS HAVE YOU USED? (EX. MEDICATIONS, TENS UNITS, ETC.)												
EXPOSURE TO HAZARDOUS MATERIALS?: Y N								**WHAT TYPE?:**				

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CIRCLE)			
MIGRAINE	ASTHMA	HEART SURGERY	HEPATITIS
STROKES	PNEUMONIA	HEART ATTACK	URINARY INFECTIONS
SEIZURES	TUBERCULOSIS	PACEMAKER/DEFIB	KIDNEY STONES
THYROID	RHEUMATIC FEVER	STOMACH ULCER	HIV/AIDS
DIABETES	POLIO	COLON POLYPS	ARTIFICIAL HIP
LIST ANY OTHER KINDS OF CANCER YOU HAVE HAD:			

LIST MAJOR SURGICAL PROCEDURES AND DATES:

HAVE YOU EVER HAD *PREVIOUS* RADIATION TREATMENTS? Y N
IF YES, WHAT CLINIC OR HOSPITAL?
APPROXIATE DATE OF PREVIOUS RADIATION TREATMENT:
TO WHAT AREA(S) OF YOUR BODY?
HAVE WE LEFT ANYTHING OUT THAT YOU ARE CONCERNED ABOUT OR FEEL IS IMPORTANT TO YOUR HEALTH?
RADIATION TREATMENTS ARE TYPICALLY DELIVERED ***DAILY*** OVER MULTIPLE WEEKS. WILL *DAILY* TRANSPORTATION TO THE CLINIC BE A PROBLEM FOR YOU? Y N _____

PATIENT SIGNATURE:

FOR OFFICE USE ONLY

VITALS: BP_____ T _____ P _____ R _____ WT._____ HT. _____
REVIEWED BY:

RADIATION
SC ONCOLOGY

Notice of Privacy Policies

I have received a Notice of Privacy Polices and know that I may review and/or receive a copy at any time from South Carolina Oncology Associates.

Patient Signature _____ Date _____

SCOA is authorized to release protected health information to the entities named below. The purpose of this authorization is to protect your personal health and financial information from being released to non-healthcare personnel without your permission.

Name each person/entity that you approve information to be released	Description of information to be released
Example: John Doe *Relationship: Spouse*	*Medical* ☒ *Other* _____ *Billing* ☒
Name: Relationship	Medical ☐ *Other* _____ Billing ☐
Name: Relationship	Medical ☐ *Other* _____ Billing ☐
Name: Relationship	Medical ☐ *Other* _____ Billing ☐

May we call leave a message on your home voice mail (or machine)? Yes ___ No ____
May we leave a message for you to return our call with any person at your home number? Yes ___ No ___
If so whom? _____

May we call and leave a message on your work voice mail (or machine)? Yes ___ No ____
May we leave a message for you to return call with any person at your work number? Yes ___ No ___
If so whom? _____

Medical records are confidential; therefore, we would like your permission to release medical information if needed to any hospital, research facility, lab or physician as it pertains to your treatment.

_____ _____
Patient Signature Date

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending a written notification to Nicole Snider at 166 Stoneridge Dr., Columbia, SC 29210.

I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure be the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be contingent on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative Date

SOUTH CAROLINA ONCOLOGY ASSOCIATES, P.A.

ASSIGNMENT OF INSURANCE AND RELEASE & ASSIGNMENT

RADIATION
SC ONCOLOGY

COPY OF INSURANCE CARD(S) ATTACHED: YES NO

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures and other pay a percentage of the charge, to the extent allowed by the law and/or contract. It is the patient's ultimate responsibility to pay the deductible amount, co-insurance, or any other balance not paid by the insurance company. If we are filing your claim we will allow forty-five days from the filing date for the carrier to process your claim and make payment accordingly. If the payment from the insurance company is not received within the time frame specified above we will bill you for delivered services. Billing is only done as a courtesy to the patient and is not a release of financial responsibility for the patient. I certify that I have read and understand fully the provider's billing policy and agree to make a payment in full and/or satisfactory arrangements when asked to do so as specified.

To the extent necessary to determine liability for payment and to obtain reimbursement from third parties, I authorize disclosure of portions of my patient's records to such third parties. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to South Carolina Oncology, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that, to the extent allowed by law and/or contract, I am financially responsible for all charges whether or not they are paid by the insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

_____ Date _____
(Patient's Signature)

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to South Carolina Oncology Associates, P.A. for any services furnished by that physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ Date_____
(Patient's Signature)

MEDICAID

I hereby authorize the Attending Physician to furnish from his records any information requested by the State Health and Human Services Finance Commission to determine any benefits payable on my behalf.

_____ Date _____
(Patient's Signature)

MEDICARE SUPPLEMENTAL INSURANCE

In the event the undersigned is entitled to physician or physicians benefits of any type whatsoever arising out of any policy of insurance, insuring patient or any other party liable to patient, said benefits are hereby assigned to physician for application on patient's bill, and it is agreed that the physician may receipt for any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment.

I hereby authorize the Attending Physician to furnish from his/her records any information requested by the insurance companies listed in connection with the above assignments.

_____ Date_____
Patient's Signature)

RADIATION
SC ONCOLOGY

Our Patient Portal, which is powered by Navigating Cancer, has many things to offer, including the ability to access your lab work, your medicine list and many other health documents 24 hours a day. The portal also offers educational material and a calendar displaying your visit appointments, as well as the ability to communicate with our staff through secure messaging.

The portal is completely confidential and unless **you** give access to your portal account, you are the only person who can access or view the portal.

While we realize some people do not have frequent access to internet or email, we would still like to create a username and password unique to you. Creating the user name and password will serve to help us in assuring each patient has a "place" within our Patient Portal.

We appreciate your help in allowing us to continue to provide the best possible care to you and your family!

☐ I give my permission to the staff at Radiation Oncology, LLC (ROL) to create a username and password for the Navigating Cancer patient portal. I understand that the username is unique to me and that all information contained within the portal is completely confidential and not shared with anyone outside of Radiation Oncology, LLC.

Name _____ Date of Birth _____

Email Address: _____

Signature _____ Date _____

☐ I Decline the offer to sign up for The patient portal at this time

Date _____

RADIATION
SC ONCOLOGY

Pregnancy Assessment

Date: _____ Name: _____ EMR# _____

Your physician has referred you for radiation therapy which involves radiation exposure to your body. The physician, radiation therapist, or nurse is available to explain the procedure and answer any questions you may have.

FEMALE Patients (Childbearing age 12-55)

Section A.
Are you pregnant? (Please check one)

	Yes. Radiation therapy will be scheduled at a later time.
	No, Maybe, or Do Not Know. Please complete Section B.

Section B.
The following questions are being asked for the sole purpose of ensuring the safety of an unborn baby if pregnancy is at all possible. Please read the following statements and check all that apply.

	I have had a hysterectomy or tubal ligation.
	I am past menopause for at least 2 years (have had no periods for at least 2 years)
	Since my last menstrual period, my only sexual partner has had a vasectomy.
	I have been taking birth control pills on schedule for 6 months or longer.
	I am using an IUD, Norplant or Depo-Provera as contraception.
	I have used a condom, diaphragm, vaginal ring or hormone patch regularly for at least 6 months.
	I have not had sexual intercourse since the 1st day of my last period.
	My menstrual period began less than 10 days ago. Date:
	I am not sexually active, or I am not sexually active in a way that could result in pregnancy.

If you checked at least one box in Section B we may proceed with radiation therapy. If you have any concern that you could be pregnant, or are not able to provide the detailed information for any reason, a pregnancy test will be performed and the results reviewed before radiation therapy can be administered.

Are you breastfeeding? ( ) No ( ) Yes If yes, please call a lactation consultant at (803) 296-5379 or (803) 434-6541 for instructions on temporarily delayed/interrupted lactation.

I understand that any dose of radiation to an unborn baby (fetus) is dangerous. I agree to not become pregnant during the course of my radiation therapy and for six (6) months after my radiation therapy has finished.

_____ _____

Patient Signature (Patient or Legal Guardian of Minor Patient) Date