

Today's Date: _____

PATIENT MEDICAL HISTORY FORM

(Please print. Thank you.)

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age:** _____ Male Female **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: Preferred (_____) _____

Cell Phone: Preferred (_____) _____

Secondary Address: _____

City: _____ **State:** _____ **Zip:** _____

May we leave a message on your answering machine / voicemail? Yes No

May we send an SMS text message to your cell phone? Yes No

Email Address: _____ **May we email you?** Yes No

Preferred Language:

Ethnicity/Race: White Hispanic/Latino Black/African American Native American
 Asian/Pacific Islander Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets: _____

(Internal Use Only)

Patient Name: _____ **MRN#:** _____



Patient Name: _____ **DOB:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician (if different): _____ **Phone:** _____

Please list any additional Physicians you see: (Include Phone #):

_____ **Phone:** _____

_____ **Phone:** _____

_____ **Phone:** _____

_____ **Phone:** _____

Emergency Contact Name:

Relationship: _____ **Phone:** (_____) _____

Employment Status:

Employed/Self Employed Unemployed Retired Disabled

(Former) Occupation: _____

Name of Employer: _____ **Work Phone:** (_____) _____

Patient Name: _____ DOB: _____

Reason for this Visit: _____

Medical History: Check the items that apply to you (current or history)

- | | | | | | |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Chronic Lung (COPD) | <input type="checkbox"/> | Lupus-Autoimmune | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> |
| Pneumonia/Bronchitis | <input type="checkbox"/> | Reynaud's Syndrome | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| TB (Tuberculosis) | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> |
| Sleep Apnea | <input type="checkbox"/> | Osteoarthritis | <input type="checkbox"/> | Atrial Fibrillation | <input type="checkbox"/> |
| Colon Polyps | <input type="checkbox"/> | Chronic back pain | <input type="checkbox"/> | Congestive Heart Failure | <input type="checkbox"/> |
| Crohn's Disease | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | Heart Attack-MI | <input type="checkbox"/> |
| Diverticulitis | <input type="checkbox"/> | Fracture | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Irritable Bowel Syndrome | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Ulcerative Colitis | <input type="checkbox"/> | Neuropathy | <input type="checkbox"/> | Heartburn/Reflux | <input type="checkbox"/> |
| Stomach Ulcers | <input type="checkbox"/> | Parkinson's Disease | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> |
| GERD/Heartburn | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> | Irregular Heart Beat | <input type="checkbox"/> |
| Hiatal Hernia | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | Frequent Infections | <input type="checkbox"/> |
| Gallstones | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | Blood Disorder | <input type="checkbox"/> |
| Cirrhosis of Liver | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | Blood Clots | <input type="checkbox"/> |
| Hepatitis A/ B/ C | <input type="checkbox"/> | Glaucoma/Cataracts | <input type="checkbox"/> | Anemia | <input type="checkbox"/> |
| Pancreatitis | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | Bleeding Disorder | <input type="checkbox"/> |
| Kidney Stone | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Drug Use | <input type="checkbox"/> |
| Kidney Disease/Failure | <input type="checkbox"/> | Lymphoma | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Freq. Urinary Tract Infections | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | | |
| Enlarged prostate | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | | |
| Peripheral Vascular Disease | <input type="checkbox"/> | Problems with Anesthesia | <input type="checkbox"/> | | |

Other Medical History: _____

Cancer History:

Type: _____ Date diagnosed _____

Treatment: (type, date, and location of treatment) _____

Treating Physician: _____

Patient Name: _____ **DOB:** _____

Past Surgical History: *(Please circle and date any of the surgeries and/or procedures that you have undergone)*

Coronary Bypass	Date: _____	Knee Replacement	Date: _____
Angioplasty	Date: _____	Rotator Cuff Repair	Date: _____
Pacemaker	Date: _____	Cataract	Date: _____
Cardiac Valve surgery	Date: _____	Gallbladder surgery	Date: _____
Hemorrhoidectomy	Date: _____	Hysterectomy	Date: _____
Prostate Operation	Date: _____	Prostatectomy	Date: _____
Hernia Repair	Date: _____	Appendectomy	Date: _____
Tonsillectomy	Date: _____	Hip Replacement	Date: _____
Mastectomy	Date: _____	Lumpectomy	Date: _____
Other Operations: _____			

Social History:

Tobacco Use: *(Present and/or Past):*

- Never Smoked
- Quit smoking When? _____ How many years did you smoke? _____yr(s)
How many packs? _____/day
- Currently Smoke Cigarettes Pipe Cigars How many packs? _____/day
How many years? _____
- Chewing Tobacco

Alcohol History: *(Present and/or Past):*

- Non Drinker
- | | | | | |
|---------------------------------|----------------------------|------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Beer | number of bottles _____per | <input type="checkbox"/> Day | <input type="checkbox"/> Week | <input type="checkbox"/> Month |
| <input type="checkbox"/> Wine | number of glasses _____per | <input type="checkbox"/> Day | <input type="checkbox"/> Week | <input type="checkbox"/> Month |
| <input type="checkbox"/> Liquor | number of glasses _____per | <input type="checkbox"/> Day | <input type="checkbox"/> Week | <input type="checkbox"/> Month |

Marital Status: Married Single Widowed Divorced Other

Living Status: Lives Alone Lives with Family Lives in Nursing Home

Winter Resident Year-Round Resident

Children: Yes No

Number _____

Health Maintenance:

Sigmoidoscopy / Colonoscopy: Yes No _____ Date: _____

Findings: _____

Last Mammogram: Date: _____ Last Bone Density: Date: _____ Last Pelvic Exam: Date: _____

Influenza (Flu) Shot: Date: _____ Pneumococcal Shot: Date: _____ Last Shingles Shot: Date: _____

Last EGD: Date: _____ Last Colonoscopy: Date: _____ Last Prostate Exam: Date: _____

World Class Medicine. Hometown Care. **FLCancer.com**

Corporate Headquarters | 4371 Veronica S. Shoemaker Blvd. | Fort Myers, FL 33916

(877) 327-2228 | (239) 274-8200 | Fax (239) 278.3224

Patient Name: _____ DOB: _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:

- Weight loss
How much _____
Over what time period _____
- Fevers
- Max temp _____
- Chills
- Night sweats
- Fatigue

Eyes:

- Wear Glasses/Contact Lenses
- Blurred Vision
- Double Vision

Ears, Nose, Throat:

- Hard of Hearing or Deaf
- Ringing in Ears
- Enlarged Lymph nodes
- Chronic Sinus Problems
- Sore Throat
- Mouth Pain/Sores

Changes/Difficulty In:

- Taste
- Smell

Cardiovascular:

- Chest Pain/Angina Pectoris
- Palpitations/Heart Murmur
- Irregular Heart Beat Pressure

Respiratory:

- Chronic or Frequent Cough
- Bloody Sputum
- Shortness of Breath

Skin:

- Rashes or Itching
- Change in Skin Color or Moles
- Varicose Veins
- Skin Cancer

Gastrointestinal:

- Difficult or Painful Swallowing
- Abdominal Pain
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Lump or Sensation in Throat
- Food Sticking
- Bloating
- Belching
- Diarrhea
- Constipation
- Rectal Bleeding
- Black or Tarry Stool
- Hidden Blood in Stool
- Excessive Rectal Gas/Flatus
- Loss of Stool/Fecal Accident
- Poor Appetite
- Jaundice

Genitourinary:

- Kidney Stones
- Pelvic Pain
- Incontinence
- Burning or Pain on Urination
- Blood in Urine
- Difficult Urination
- Men: Prostate Problems

Musculoskeletal:

- Joint Pain/Arthritis
- Muscle or Joint Weakness
- Back Pain
- Bone Pain
- Muscle Aches

Neurological:

- Numbness/Tingling
- Arm or Leg Weakness
- Light-Headed/Dizzy/Fainting Spells
- Tremors/Headaches

Psychiatric:

- Anxiety/Agitation
- Depression
- Crying for No Reason
- Insomnia
- Alcoholism
- Drug Problem

Hematologic:

- Easy Bruising
- Gum or Nose Bleeding
- Blood Transfusions

Endocrine:

- Heat or Cold Intolerance
- Excessive Skin Dryness
- Excessive Thirst
- Excessive Urination
- Weight Problem
- Hot Flashes

Breast:

- Rashes or Itching
- Changing in Skin Color
- Varicose Veins
- Skin Cancer
- Breast Pain/Lump
- Breast Discharge
- Breast Rash

Allergies/Immunology:

- History of Allergies
- Chronic Infections

Patient Name: _____ **DOB:** _____

Family Medical History: Indicate any family members with cancer, blood disease or other disease

Age Disease	If deceased, cause of death	
Father: _____	_____	_____
Mother: _____	_____	_____
Siblings: _____	_____	_____
_____	_____	_____
_____	_____	_____

In your opinion, are there any diseases that run in your family? Yes No

Please list: _____

MEDICATION LIST

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

Drug Allergies: List all medication allergies

Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____

Are you allergic to:

Iodine Latex Shellfish CT Scan Dye / IV Contrast Eggs Peanuts

Other: _____

Type of Reaction: _____



AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR EMR

I authorize Florida Cancer Specialists (FCS) to take my photograph (digital camera/video may be used). These photos may then be placed in my Florida Cancer Specialists electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

Patient Signature:

Patient Name (Printed):

FCS Office Location:

Date:



REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

Name and Address of Practitioner

To be sent to Florida Cancer Specialists: *(Internal use)*

Address, City, State, Zip Code

Fax/Telephone Number

_____ I give permission to Fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Cancer Specialists to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

Print Patient Name

Date

Patient Date of Birth

Signature Patient, Parent, or Legal Guardian/Representative

Date

World Class Medicine. Hometown Care. **FLCancer.com**

Corporate Headquarters | 4371 Veronica S. Shoemaker Blvd. | Fort Myers, FL 33916

(877) 327-2228 | (239) 274-8200 | Fax (239) 278.3224



CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

Please check one of the following:

_____ **I give my permission to the employees of Florida Cancer Specialists & Research Institute to disclose my Protected Health Information to me and the following family or friends:**

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

_____ I request that all my Protected Health Information be disclosed **ONLY** to me and no other family or friends.

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

Patient – Signature

Date

Patient – Print Name



Patient Name: _____ DOB: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? Yes No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? Yes No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder: _____

Policy#/Bin# _____

I certify that the information provided is accurate. I will notify FCS of any changes as soon as they become available. I will notify the doctor/staff to any changes or additions at subsequent visits.

Print Patient Name

Date

Signature Patient or Legal Guardian or Representative

Date



FINANCIAL POLICIES AGREEMENT

Dear FCS Patient,

Thank you for choosing Florida Cancer Specialists & Research Institute (FCS) as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge FCS's patient financial policies:

- You promise to provide FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify FCS if your coverage changes.
- You understand that FCS patient financial policies are available online at www.flcancer.com. You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that FCS will bill your insurance plan or program for services provided by FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to FCS and are authorizing payment to be made directly to FCS.
- You agree you are responsible for payment to FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, FCS will use your personal health information internally and will share such information with your health care payer/plan and certain business associates of FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- FCS owns and operates RxToGo, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use RxToGo and may have your prescriptions filled wherever you choose. However, if you select RxToGo to fill FCS-issued prescriptions, then this policy and all other FCS patient financial responsibility policies will also apply to the items and services provided to you by RxToGo.
- You acknowledge that laboratory services may be necessary as part of your care and treatment which may be performed by FCS clinicians at FCS's own laboratory facilities. In some cases, laboratory services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside laboratory provider.

World Class Medicine. Hometown Care. **FLCancer.com**

Corporate Headquarters | 4371 Veronica S. Shoemaker Blvd. | Fort Myers, FL 33916

(877) 327-2228 | (239) 274-8200 | Fax (239) 278.3224



- If you make a payment to FCS that results in a surplus on your account (i.e., a credit balance), FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of FCS's care a credit balance remains which is not subject to return to your insurer or other payer, FCS will refund the credit balance to you. However, you agree that any refund under \$10.00 will be made **only** if you make a written request and, in any event, any credit balance under \$10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.
A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST**

Printed Name of Patient

Date

Signature of Patient (or Patient's Legal Representative)

Printed Name of Legal Representative and Relationship to Patient

For office use:

Signature of Witness (FCS Employee)

Printed Name of FCS Witness



MEDIGAP

Name of Beneficiary: _____

Health Insurance Claim Number: _____

Medigap Policy Number: _____

I request that payment of authorized Medigap benefits be made on my behalf to Florida Cancer Specialists or Rx TO GO for any services furnished by _____. I authorize any holder of medical information about me to release to _____ any information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Signature



Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of Florida Cancer Specialists & Research Institute Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Florida Cancer Specialists & Research Institute facility or by submitting a request in writing to the corporate office at Florida Cancer Specialists & Research Institute, 4371 Veronica S. Shoemaker Blvd., Fort Myers, FL 33016.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting Florida Cancer Specialists & Research website at FLCancer.com, select the **Patient Guide** tab, select **New Patient Forms** and click on **Notice of Privacy Policies**.

Date: _____

Accepted _____ Declined _____

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

Guardian/Representive Signature: _____ Date: _____

Relationship to Patient: _____

World Class Medicine. Hometown Care. **FLCancer.com**

Corporate Headquarters | 4371 Veronica S. Shoemaker Blvd. | Fort Myers, FL 33916

(877) 327-2228 | (239) 274-8200 | Fax (239) 278.3224