TEXAS ONCOLOGY

New Patient & Family History

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Gender: ☐ Male ☐ Female Marital Status: (Please check one) ☐ Married ☐ Single ☐ Divorce ☐ Widow ☐ Other:_____

Telephone (1st call): (___) _____ Telephone (2nd call): (___) _____

Referring Physician:_____
Name Address City State Zip Code

Primary Care Physician:_____
Name Address City State Zip Code

Number of Children:_____ Ages:_____

What is your primary language? _____

Who lives with you? (Please check all that apply) ☐ I live alone ☐ Spouse ☐ Children ☐ Parents ☐ Friend ☐ Other:_____

Who helps at home?_____

Person(s) with your Medical Record Access: _____
Name Relationship Telephone

Have you executed a Durable Power of Attorney, Directive to Physician and/or Living Will? ☐ Yes ☐ No
Would you like additional information regarding these documents? ☐ Yes ☐ No

If you have signed one of these legal documents then please speak to the nurse regarding your decisions and bring a copy with you to your appointment

Do you have daily transportation available? ☐ Yes ☐ No

I am currently: Working: ☐ Yes ☐ No Work Schedule is: ☐ Full-time ☐ Part-time ☐ Sick Leave ☐ Retired ☐ Disability

What type of work do you currently do or have done?_____

Do you use any of the following? (Please check all that apply)

Alcohol: Yes No What type?_____ How much?_____ How often?_____ If quit, when?_____

Tobacco: Yes No What type?_____ How much?_____ How often?_____ If quit, when?_____

Caffeine: Yes No What type?_____ How much?_____ How often?_____ If quit, when?_____

Recreational Drugs: Yes No What type?_____ How much?_____ How often?_____ If quit, when?_____

Sunscreen: Yes No

How much time do you spend exercising each week?_____ What type of exercise?_____

Do you need to use any of the following? (Please check all that apply) Cane Walker Wheelchair Oxygen

Other: _____

Do you do monthly self-exams? (Please check all that apply) Skin cancer: Skin Mole Other:_____

Female: Breast Yes No Have you ever been trained properly for breast self-exam? Yes No

Male: Testicles Yes No Have you ever been trained properly for testicular self-exam? Yes No

Are you diabetic? Yes No If yes, what type:_____

If yes, how is it controlled: Diet Oral Medications Insulin Other: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): Yes No If yes, how is it controlled:_____

Reproductive History:

Female: Number of pregnancies:_____ Number of children: _____ Age at first pregnancy:_____

Did you breast feed: Yes No If yes, how many months (approximate): _____

Age at first period:_____ Age at menopause: _____ Age at last period:_____

Hysterectomy: Yes No Ovaries intact: Yes No If *no*, please explain:_____

Hormone use: Yes No Sex Drive: Yes No Method of birth control:_____

Male: Impotence (Erectile Dysfunction): Yes No Sex Drive: Yes No

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

New Patient & Family History

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

What is your understanding of why you are being seen:_____

Additional Medical Condition History

(If additional space is needed then please copy this page)

Diagnosis / Condition	Physician Name	Physician Office #	Date Occurred

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Please list the names of hospital(s) or clinic(s) where you had x-rays in the last six months:_____

Preventive Health Maintenance

(Please provide dates for each or answer "none")

Female:
Last mammogram:_____
Last pap smear:_____
Last colonoscopy:_____
Last bone density scan:_____
Last pneumonia vaccine:_____

Male:
Last colonoscopy:_____
Last prostate exam:_____
Last PSA screening:_____
Last pneumonia vaccine:_____

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below

(M) = Maternal **(P) = Paternal** (If additional space is needed then please copy this page)

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	Living Deceased		Grandmother (P)	Living Deceased	
Father	Living Deceased		Grandfather (P)	Living Deceased	
Children	Living Deceased		Aunt(s)	Living Deceased	
Brother(s)	Living Deceased		Uncle(s)	Living Deceased	
Sister(s)	Living Deceased		Cousin(s)	Living Deceased	
Grandmother (M)	Living Deceased		Other:		
Grandfather (M)	Living Deceased		Other:		

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship:_____
Name Relationship

Nurse Name:_____ Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

Medication and Allergy List

Today's Date:_____

Patient Name:_____ _____
Last First Middle or Maiden Date of Birth

Please list ***all*** prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

(If additional space is needed then please copy this page)

Medication	Strength	Dose	How many times a day

** Allergies **

Medication (Include prescription, over-the-counter and/or vitamins)	Describe Reaction

Have you ever had an allergic reaction to: Contrast Dye Iodine Shell Fish

What type of reaction did you have: Hives Shortness of breath Other:_____

Additional Comments and/or Information:_____

_____

Pharmacy Information

_____ (____) _____
Pharmacy Name Phone Number

_____
Address City State Zip Code

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

Prescription History Consent

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect as long as I attend or receive services from Texas Oncology, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

Date: _____

Print Name (Patient): _____ **DOB:** _____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Texas Oncology Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Texas Oncology cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge I have received a paper copy of the Texas Oncology-Notice of Privacy Practices.
_____ **(Patient's Initials)**

Please return completed form to the appropriate physician's office.

Patient Confidentiality Questionnaire

TEXAS BREAST SPECIALISTS
Higher Standards. Greater Hope.

Please list the family members or other persons, if any, that we may inform about your general medical condition, your diagnosis, appointments, lab results, x-ray results and/or other health information:

Name: _____ Relation: _____

Phone: _____ Consent to leave a message Yes No

Name: _____ Relation: _____

Phone: _____ Consent to leave a message Yes No

Please list the family members or other persons, if any, that we may inform about your general medical condition **ONLY IN AN EMERGENCY**:

Name: _____ Relation: _____

Phone: _____ Consent to leave a message Yes No

Name: _____ Relation: _____

Phone: _____ Consent to leave a message Yes No

Please list where you would prefer to have your billing statement and/or correspondence from our office sent if other than your home address.

Address: _____

City: _____ State: _____ Zip: _____

Please list the persons, if any, that you **DO NOT** want informed about your general medical condition, your diagnosis, appointments, lab results, x-ray results and/or other private health information. If there are revisions to this list after this dated submission, please notify the Texas Oncology staff. This authorization will remain in effect until revoked by you in writing.

1. Name: _____ Relation: _____

2. Name: _____ Relation: _____

Patient Name: _____

Patient Signature: _____ Date: _____

Name: _____
(if authorized representative)
Relation: _____ Signature: _____ Date: _____

TEXAS ONCOLOGY

Assignment of Benefits and Financial Responsibilities

Patient Name: _____ (Last) _____ (First) _____ (M.I.) _____ (Date of Birth) _____ (Age)

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Email Address: _____

Gender: Male Female Marital Status: Married Single Divorced Widowed

Home Health / Hospice (Name): _____

The Texas Cancer Incident Reporting Act requires cancer incidence reporting to the Texas Cancer Registry (TCR) mandatory. Primary racial origin captures information used in research and cancer control activities.

Race: Caucasian African American Hispanic Asian/Indian/Pakistani/Sri Lankan Chamorran Chinese Fiji Islander Filipino Guananian NOS Hawaiian Hmong Japanese Kampuchean/Cambodian Korean Laotian Melanesian NOS Micronesian NOS Native American New Guinean Other Asian including Asian NOS and Oriental NOS Pacific Islander NOS Polynesian NOS Samoan Tahitian Thai Tongan Vietnamese Other

Employer: _____ (Name) _____ (Address) _____ (City) _____ (State) _____ (Zip)

Responsible Party: _____ (Name) _____ (Relationship) ( ) _____ (Telephone)

Emergency Contact

Spouse/Next of Kin: _____ (Name) _____ (Relationship) ( ) _____ (Telephone)

Alternate Emergency Contact: _____ (Name) _____ (Relationship) ( ) _____ (Telephone)

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ Telephone: ( ) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Telephone: ( ) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

Tertiary Insurance: _____ Telephone: ( ) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Texas Oncology P.A.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Texas Oncology P.A. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Texas Oncology P.A.
4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A.
5. I understand the Texas Oncology patient portal will use my email address to send me information about accessing my patient information online.

Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ Patient Signature _____ Date/Time AM or PM (*circle one*)

_____ Responsible Party Signature _____ Relationship _____ Date/Time AM or PM (*circle one*)

PHYSICIAN:	ACCT #:	LOC:	EMPLOYEE INITIALS:

Please return completed form to the appropriate physician's office.

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name
(First Name, Middle Initial, Last Name)

Email Address of Patient/Authorized User

Date of Birth of Patient

Physician's Name

Authorized User is:

- Patient
- Patient's Designee

Patient's Designee's Name (Printed)

Patient's Designee's Signature

Patient's Medical Record Number

Patient's Signature

Date

Signature of Practice Staff
[confirming user's identity and authority]

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient.

Staff Use Only:	MRN_____
Email in PMS or iKM_____	iKM Consent_____

Notice to Patients (Copays)

TEXAS BREAST SPECIALISTS
Higher Standards. Greater Hope.

If your insurance requires a copay for your services, we have a responsibility to collect this from you. If we do not collect a copay, ware are in violation of our contract with the insurance company and could lose our ability to provide services for that carrier. We make every effort to be correct in asking for copays. If you feel that we have asked you in error, please call it to our attention and we'll research your coverage to be sure a copay is required.

Besides visits to the doctor, there are other situations that may require a copay. Examples are as follows (not inclusive):

1. Port/line flushes, lab draws and/or dressing changes
2. A visit with the nurse that requests a doctor interaction
3. Daily chemotherapy (not seeing a doctor)
4. Daily radiation therapy

Patient Name: _____

Patient Signature: _____ Date: _____

Name: _____
(if minor or authorized representative)

Relation: _____ Date: _____

TEXAS ONCOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Oncology.

Name: (Please Print):_____

Signature:_____

Name of Personal Representative (if appropriate):_____

Signature of Personal Representative (if appropriate):_____

Date: _____

Texas Oncology Use Only
Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____
_____
_____
_____

TEXAS ONCOLOGY

*G*enetic *R*isk *E*valuation *A*nd *T*esting Program

Hereditary Cancer Risk Assessment Form

Patient Name (print): _____ **DOB:** _____ **Phone (Day):** _____

Most cancer happens by chance and is not passed through families. However, in some families, cancer may be due to specific genetic factors that can be passed from parent to child. Identifying these hereditary families can help to determine the risk of cancer for individuals and their relatives. Individuals at hereditary risk for cancer have medical options to increase the chances of finding cancer early and reduce the risk of a first or second cancer. A careful review of the family history is an essential first step in identifying high-risk families. Please complete the family history check list below:

If you have or had cancer, what type(s): _____ **Age Diagnosed:** _____

Please check the boxes below. Please include only blood relatives and consider your mother and father's side of the family separately.

Is there a Personal or Family History of:	**Have YOU had:**	**Do you have a family history of:**	**Please list the relative(s) and the type of cancer (Ex: mom - breast & maternal aunt - ovarian)**
Breast cancer at or before age 50?	↑	↑	
Triple Negative Breast Cancer at or before age 60? (ER/PR/HER2 negative cancer)	↑	↑	
Two primary breast cancers in the same person?	↑	↑	
2 relatives on the same side of the family with breast cancer with one diagnosed at or before age 50? (you may count yourself)	↑	↑	
Ovarian Cancer at any age?	↑	↑	
Breast & Ovarian cancer in the same person?	↑	↑	
Male Breast Cancer at any age?	↑	↑	
3 or more relatives with breast, ovarian, pancreatic and/or aggressive prostate cancer on the same side of the family at any age (you may count yourself)?	↑	↑	
Colon Cancer before age 50?	↑	↑	
Uterine Cancer before age 50?	↑	↑	
Abnormal MSI or IHC tumor test results? (testing done on colon or uterine tumors)	↑	↑	
2 or more of the following cancers in the same person OR 2 or more relatives on the same side of the family with one of the following cancers: colon, uterine, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas? (you may count yourself)	↑	↑	
10 or more polyps in the colon?	↑	↑	
2 or more Melanomas in the same person?	↑	↑	
Melanoma and pancreatic cancer in the same person?	↑	↑	
3 or more relatives with melanoma and/or pancreatic cancer at any age on the same side of family (you may count yourself)?	↑	↑	
A known mutation (gene change) in a cancer gene?	↑	↑	
Ashkenazi (Central/Eastern European) Jewish Ancestry and a personal or family history of breast, ovarian or pancreatic cancer?	No: ↑ Yes: ↑ Maternal ↑ Paternal ↑ Both Sides		
Do you have any other concerns about your personal or family history of cancer?	If yes please describe:		

If any of the boxes are checked YES, you are a candidate for the Genetic Risk Evaluation and Testing Program. Please discuss with your physician.

_____ _____ _____ _____

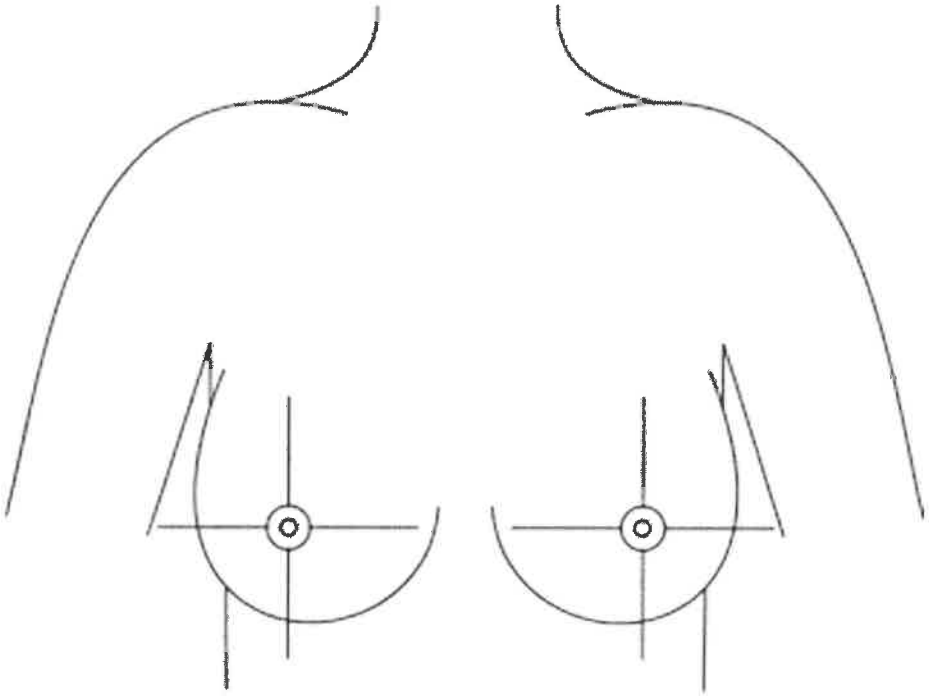
Patient Signature ***Date*** ***Health Care Provider*** ***Date***

Physician Notes

TEXAS BREAST SPECIALISTS
Higher Standards. Greater Hope.

Today's Date: _____

Patient Name: _____ Date of Birth: _____



TEXAS ONCOLOGY

Consent / Authorization for Release of Information

1. I hereby authorize:

   Name: _____ Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ FAX: _____

   To release the following information from the health record (s) of

   Patient's Name: _____

   Phone Number: _____ Date of Birth: _____

   Covering the period (s) of treatment: From: _____ To: _____

2. Information to be released:

   Progress Note — Mail Copies: _____

   Radiology — Patient Pick-Up: _____

   Lab — FAXED: _____

   Billing Records

   X-ray Films

   Complete Medical Record (includes information regarding insurance, demographic, referral documents and records.)

3. Information is to be released to:

   Name: _____ Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ FAX: _____

   Purpose of disclosure (circle one):
   Treatment **Payment** **Health Care Operations** **Other (Specify Below)**

   _____

4. I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology® in writing.

   I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

5. **THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.**

6. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

7. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

*There is a $25.00 fee for the first 20 pages, and $.50 cents per each additional page when applicable.
Please allow two weeks notice for releases.

Signature: _____ Date: _____
Patient or Legal Representative

Witness: _____ Relationship: _____

Patient Name: _____ Date: _____

Review of Symptoms

Please indicate if you have any of the following problems now or in the past. If no problems are present in a category, please circle the bolding heading. Height: _____ Weight: _____ lbs

General
- Fever
- Night sweats
- Weight gain/loss_____ lbs
- Poor appetite

Eyes
- Dry eyes
- Blurred vision
- Doubled vision
- Cataracts
- Glaucoma
- Spots

Other_____

Skin
- Itching
- Rash
- Eczema
- Sores

Other_____

Ear Nose Mouth Throat
- Difficulty hearing
- Ear pain
- Frequent nosebleeds
- Nose/sinus problems
- Sore throat
- Bleeding gums
- Snoring
- Dry mouth
- Oral abnormalities
- Teeth abnormalities

Last Dental Exam _____

Respiratory
- Cough
- Wheezing
- Difficulty breathing

Other_____

Allergy
- Runny nose
- Sinus pressure

Other_____

Joints & Muscles
- ☐ Joint pain (where) _____
- ☐ Swollen joints (where) _____
- ☐ Back pain _____

Other_____

Cardiovascular
- Chest pain
- Angina
- Palpitations
- Pounding heart
- Irregular pulse
- Swollen feet
- High blood pressure

Genito-Urinary System
- Burning
- Dark or bloody
- Stones
- Infection
- Difficulty urinating
- Incontinence

Other_____

Emotions
- Depressed
- Sleep disturbance
- Nervous

Other_____

Neurology
- Loss of consciousness
- Weakness
- Seizures
- Dizziness
- Headaches

Other_____

Endocrine
- Fatigue
- Increased thirst
- Hair falling out
- Increased hair growth

Digestion
- Difficulty swallowing
- Nausea
- Heartburn
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Bleeding
- Black stool

Other_____

Hematology/Lymphatic
- Swollen glands
- Bruising
- Bleeding problems

Pain Level Scale

1 least painful to 10 most painful

_____

MEN
- Prostate issues
- Last exam

How many times do you urinate each night? _____

WOMEN
- Hot flashes
- Irregular periods
- Missed periods

Last pap smear _____

Last Mammogram _____

Preventative Health Maintenance

Last Low Dose CT _____

Smoker Yes No

If yes, how many per day _____

Have you and/or immediate family had any Genetic Testing for Cancer? Yes No

If yes, when _____

Last Flu Shot _____

Other Medical Problems

_____

_____

_____

_____

_____

_____