WEST
CANCER CENTER
& RESEARCH INSTITUTE

Patient Information Form

Welcome to West Cancer Center. We want to provide excellent service. In order to help us contact you and properly handle your insurance and billing, please fill out the information below.

General Patient Information:

Patient Name: _____ Date of Birth: _____

SSN: _____ ☐ Male ☐ Female

Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile Phone: _____ Contact Preference: Home / Work / Mobile

Spouse (Next of Kin): _____ Relationship: _____ Phone: _____

Employer: _____ Work Phone: _____

Insurance Information:

Primary Pharmacy: _____ Phone: _____

Pharmacy Cross Streets or Address: _____

Primary Insurance: _____ Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Holder: _____ Policy Holder DOB: _____

**Please provide a copy of your insurance card upon arrival.*

Information Required by Federal Government:

Race: ☐ Caucasian/White ☐ African American/Black ☐ American Indian ☐ Asian ☐ Other

Ethnic Background: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: _____

Patient Representative Identification Form

PATIENT NAME: _____ **DOB:** _____

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.

Please list ALL PERSONS you wish to have access to you Protected Health Information (PHI): (i.e. those making appointments or checking on test results)

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Please list your emergency contact:

Name:_____ Phone:_____ Relationship:_____

Please list those whom we can discuss your bill:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

If applicable, please list your Legal Representative?

Name:_____ Phone:_____ Relationship:_____

By what authority is this person your Legal Representative? (Please check one)

☐ 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 up to two (2) patient identifiers.

Patient Signature: _____ Date: _____

Clinical History Form

Chief Complaint: (Reason for your visit) _____

Referring Physician: _____

Primary Care Physician: _____

Past/Present Illness:

	Yes	How long?		Yes	How long?
Heart and Blood Vessels			**Kidney/Bladder**		
Anemia			Kidney Disease		
Angina			Kidney Stones		
Heart Attack			Urinary Tract Infection		
Heart Disease/Failure			**Blood Disorders**		
High Blood Pressure			Bleeding with tooth extraction		
Irregular Heartbeat			Blood Clots/Clotting disorder		
Peripheral Vascular Disease (PVD)			Easy bruising		
Stent Placement			**Immune System**		
Stroke/TIA			Other Collagen Vascular Disease		
Brain and Nerves			Human Immune Virus (HIV)/AIDS		
Glaucoma			Lupus		
Migraines			**Joint/Skelton**		
Multiple Sclerosis			Arthritis		
Parkinson's Disease			Rheumatoid Arthritis		
Seizures or Epilepsy			**Endocrine**		
Lungs			Diabetes or Sugar Issues		
Chronic Bronchitis			Thyroid Disease or Goiter		
Emphysema/COPD			**Psychological**		
Pneumonia			Anxiety		
Sleep Apnea			Depression		
Tuberculosis (TB)			Psychiatric Treatment		
Stomach/Intestines			**Other**		
Colitis			GYN Problems		
Crohn's Disease			Hepatitis/Liver Disease		
Diverticular Disease			Sinusitis		
Gall Bladder Disease			Vision Problems		
Pancreatitis			Other:		
Ulcers of Stomach or Duodenum			Other:		
Skin			Other:		
Psoriasis			Other:		
Skin Condition(s)			Other:		

Personal Cancer History:

Please complete the following regarding the treatment of your prior cancer(s):

Cancer Type		Yes/No	Date Treated	Treating Physician	Where?
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				

Past Surgeries:

None: (please check box if none) ☐

	Surgery Type	Date	Hospital Performed	Surgeon Name
Surgery 1				
Surgery 2				
Surgery 3				
Surgery 4				

Are you under the care of a cardiologist? ☐ Yes ☐ No Doctor Name: _____

Do you have any surgical hardware (please check yes for all that apply)?

☐ Hip ☐ Valve(s) ☐ Pacemaker ☐ Defibrillator ☐ Aneurysm Clip

☐ Mechanical Stimulating Device (Neuro Stimulator, Infusion Pump, etc) ☐ Other _____

Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when? _____ Where? _____

Have you ever had polyps? ☐ Yes ☐ No If yes, when? _____

Please list any other physicians you currently see:

Physician Name	Specialty
_____	_____
_____	_____
_____	_____

Allergies and Reactions:

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to contrast IV? ☐ Yes ☐ No

Have you had any vaccinations? ☐ Yes ☐ No

If yes which? _____

Please list any allergies and reactions:

Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____

Social History:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Lives with: _____

Do you have your own transportation? ☐ Yes ☐ No

Highest Education Level: _____

Do you smoke? ☐ Yes ☐ No

If yes, estimate how many packs a day: _____ If yes, how many years? _____

Are you a former smoker? ☐ Yes ☐ No

If yes, how many years did you smoke? _____ If yes, when did you quit smoking? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you have a history of recreational drug use? ☐ Yes ☐ No If yes, what type? _____

Gender Information:

For Clinical Use Only (please answer if applicable).

What sex were you assigned at birth or what is your legal sex?

☐ Female ☐ Male

What is your current gender identity?

☐ Female ☐ Male ☐ Trans female to male ☐ Trans male to female ☐ Questioning/Unsure

☐ Decline to state ☐ Other _____

What is your sexual orientation (or do you think of yourself as)?

☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Pansexual

☐ Questioning/Unsure ☐ Something else ☐ Decline to state

Other:

If you are a female under 45 years old, how important is fertility maintenance to you?

☐ Not ☐ Somewhat ☐ Very

If you are a male under 50 years old, how important is fertility maintenance to you?

☐ Not ☐ Somewhat ☐ Very

Do you have any other health information you would like to add?

_____

_____

_____

_____

Family Medical History Form

Patient Name: _____

What is your ancestry: (English, German, African, etc.) _____

Are you of Eastern European Jewish Ancestry/Ashkenazi? ☐ Yes ☐ No

Do you have any relatives with cancer? ☐ Yes ☐ No

Would you be interested in speaking with someone about your history of cancer? ☐ Yes ☐ No

Family Member	Chronic Disease or Conditions	Cancer Site (ex. breast, colon)	Age Detected	Living (L) or Deceased (D)	Current Age or Age at Death
Mother					
Father					
Sisters					
Brothers					
Children					

Family Member	Maternal	Paternal	Chronic Disease or Conditions	Cancer Site	Age Detected	Living (L) or Deceased (D)	Current Age or Age at Death
Grandfathers							
Grandmothers							
Aunts							
Uncles							
First Cousins							

Have anyone in your family undergone genetic testing for hereditary syndrome cancer? Yes ☐ No ☐

If yes, please list family members: _____

_____

Breast and Reproductive History Form

(For Female Patients Only)

Do you have: (check all that apply)

☐ Yes	☐ No	Abnormal Mammogram	If yes,	☐ Left Breast	☐ Right Breast
☐ Yes	☐ No	Lumps	If yes,	☐ Left Breast	☐ Right Breast
☐ Yes	☐ No	Breast Pain/Tenderness	If yes,	☐ Left Beast	☐ Right Breast
☐ Yes	☐ No	Nipple Discharge	If yes,	☐ Left Breast	☐ Right Breast
☐ Yes	☐ No	Skin Changes	If yes	☐ Left Breast	☐ Right Breast

Other: _____

Breast History:

Have you ever had a mammogram? ☐ Yes ☐ No

If Yes, When was your last mammogram? _____ Where? _____

Have you ever had a breast ultrasound? ☐ Yes ☐ No

If Yes, When was your last ultrasound? _____ Where? _____

Have you ever had breast implants? ☐ Yes ☐ No

Do you perform monthly breast self-examinations? ☐ Yes ☐ No

Have you ever had a breast biopsy (removal of a piece of breast tissue)? ☐ Yes ☐ No

If yes, when? _____ If yes, were your results abnormal? ☐ Yes ☐ No

Gynecologic History:

At what age did you have your first period? _____

Are you pregnant now, or is there a possibility that you could be? ☐ Yes ☐ No

How many times have you been pregnant? _____ How many children have you given birth to? _____

How old were you when you gave birth to your first child? ___ Are you post-menopausal? ☐ Yes ☐ No

What is the date of your last pap smear? _____

If you are post-menopausal, how old were you when you stopped having periods? _____

Have you had your uterus removed? ☐ Yes ☐ No

Have you had your ovaries removed? ☐ Yes ☐ No

Have you ever taken oral contraceptives for birth control? ☐ Yes ☐ No If yes, for how long? _____

Are you currently still taking oral contraceptives? ☐ Yes ☐ No

Have you ever taken hormone replacement therapy (estrogen or progesterone)? ☐ Yes ☐ No

Are you still taking them? ☐ Yes ☐ No If not, how long have you been off? _____

Do you currently have hot flashes or night sweats? ☐ Yes ☐ No

Are they ☐ Mild ☐ Moderate ☐ Severe

Your Medicine Guide

Your doctor needs to know all of the medicine you take. This covers medicines you buy from a pharmacy or buy off the shelf at a store.

Your doctor will probably order medicine for you. But, some drugs do not work well with others. When some drugs are mixed, they may have side effects that make you sick.

To keep you safe, it is important that you make a list of all your medicine and keep it up-to-date.

BEFORE YOUR DOCTOR VISIT:

1. **Make a list of <u>all</u> your medicines** on the next page. If it is easier, you may bring your medicines with you. We are happy to write the list for you.
2. **Put the list in the envelope** after you have filled it out.
3. **Bring the envelope** to all of your doctor visits.

We will update your Medicine Guide at every doctor visit. We will give you a new copy to keep in your envelope.

Most pharmacies now have apps that will list your drugs for you if you have a Smart Phone.

- Walgreens
- Target
- K-Mart
- Kroger
- Walmart
- Ride Aide
- CVS
- Costco
- Fred's

Talk to the pharmacist to help you keep track of your medicines.

If you have questions, please call West Cancer Center at 901-683-0055 to speak with a nurse.

Patient Name: _____

Date of Birth: _____

Name of Medicine	Dose (strength/ milligrams)	Frequency (How often do you take this medicine)	Why do you take this medicine?	Start Date (When did you start taking this medicine?)	Do you have any problems with this medicine? Yes or No	Prescribing Doctor

Patient Name: _____

Date of Birth: _____

Name of Medicine	Dose (strength/ milligrams)	Frequency (How often do you take this medicine)	Why do you take this medicine?	Start Date (When did you start taking this medicine?)	Do you have any problems with this medicine? Yes or No	Prescribing Doctor

Authorization for Medical Records Form

Please complete and sign this form so West Cancer Center can request your medical records from other providers.

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

Please choose and initial A or B below:

_____ A. Complete medical record which may contain treatment notes regarding radiology, pathology (including HIV test results and genetic testing information), immunization, procedure(s), **alcohol or 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: _____

_____

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. It 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 may 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 upon request.
- I understand that this authorization is voluntary.

_____ _____
Signature of Patient or Patient Representative Date

(Form must be completed before signing)
Printed name of patient representative: _____

Description of the Representative's authority to act on behalf of patient: _____

Relationship to the patient: _____

**For information about how your medical information may be used or disclosed, please see the Patient Notice.*

Patient Responsibilities

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, Worker's 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 one 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.

If you do not have 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 The West Clinic Financial Policy and authorize The West Clinic, P.C. 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 of The West Clinic, P.C.

Patient or Patient 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 Representative Signature: _____ Date: _____