Patient Information

Welcome to West Cancer Center. We want to provide you with 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:_____________

Spouse (Next of Kin): ____________ Relationship:_________________ Phone: __________________

Employer: _____________________________________ Work Phone: ___________________________

The below information will be used to contact you. Please only provide information for any method you prefer West Cancer Center use for contact (e.g., work phone, mobile phone).

Email Address:__________________________ Home Phone:_________________________________

Work Phone:_______________ Mobile Phone (voice and text):_______________

Contact Preference: Home / Work / Mobile/ Email

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:____________________________________

Do you need language translation assistance? ☐ Yes ☐ No

Do you need interpreter aids or assistance? ☐ Vision ☐ Hearing ☐ Other

Do you require a physical accommodation? ☐ Yes ☐ No

If Yes, please let us know what type of accommodation is required.

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 West Cancer Center and present a copy even if one is created after my initiation of care.

Patient Representative Identification

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. Persons involved in your care or payment for care, such as a family member or caretaker may have access to your health information related to their involvement unless you indicate otherwise. In addition, your legal representative may access or receive your health information on your behalf.

Please list ALL PERSONS you wish to have access to your 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 those with whom we can discuss your bill:

Name:_____________________ Phone:_____________________ Relationship: _______________

Name:_____________________ Phone:_____________________ Relationship: _______________

Name:_____________________ Phone:_____________________ Relationship: _______________

Please list your Emergency Contact:

Name:_____________________ Phone:_____________________ Relationship: _______________

NOTE: In an Emergency, HIPAA permits release of PHI as necessary for informing your Emergency Contact of your location and condition.

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 and documentation of legal representation.

Patient/Patient Representative Signature: ______________________________________

Date: ____________________________

4844-7508-8861.1

Clinical History

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

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

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

(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 Breast	☐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 all your medicines.** Please use the form 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. **Bring this list to all of your appointments**.

We will update your Medicine list at every doctor visit. We will give you a new copy

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

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

WEST
CANCER CENTER
& RESEARCH INSTITUTE

<u>Patient Financial Responsibilities</u>

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. <u>If your insurance company has not paid within 120 days of the date of service, the balance will be transferred to you</u>.

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 X68151 prior to your visit to discuss payment options.

I acknowledge receipt of The West Clinic Financial Policy and authorize The West Clinic, PLLC d/b/a West Cancer Center 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, PLLC d/b/a West Cancer Center.

Patient or Patient Representative Signature:__________________________ Date:________________

WEST
CANCER CENTER
& RESEARCH INSTITUTE

Patient Privacy Notice Acknowledgement:

I acknowledge that **West Cancer Center’s Notice of Privacy Practices** has been made available to me.

This packet is available on the West Cancer Center website, westcancercenter.org, and available for print at all front desk locations by request.

Patient or Patient Representative Signature:___________________________________

Date: ________________________

4842-0101-8845.1

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, 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 & Research Institute

For the purpose(s) of: Treatment, Payments, or Health Care Operations

I understand that I may withdraw my authorization in writing to Regional One Health Cancer Center and West Center 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 Regional One Health Cancer Center and West Cancer Center. If this authorization has not been revoked, and if I have not indicated an expiration date, this authorization will expire five (5) years 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.*