NEW PATIENT/ UPDATED DEMOGRAPHIC FORM

Please carefully read and update all information in this packet

Alabama CancerCare®

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Race: _____ Marital Status: _____ Home Phone: _____

Cell: _____ Email Address: _____

Spouse/ Next of Kin: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Pharmacy: _____ Phone: _____

Pharmacy Address: _____

Reason for Visit: _____

PATIENT MEDICAL HISTORY

Height: _____ Weight: _____

Prior Radiation: ☐ Yes ☐ No

Prior Chemotherapy: ☐ Yes ☐ No

Pacemaker: ☐ Yes ☐ No

Past Surgeries: ☐ None

Previous Surgery	Date of Surgery	Surgeons Name

Please Check All That Apply to You:

☐ Heart Attack ☐ Stroke ☐ Diabetes ☐ Blood Disorders (please describe): _____

☐ Hypertension ☐ Blood Clots ☐ Depression ☐ Cancer (please describe): _____

☐ Heart Disease ☐ Unsual Bleeding ☐ Other (please describe): _____

SOCIAL HISTORY

Alcohol use? ☐ No ☐ Yes If Yes, how many drinks do you have in a week? _____

Tobacco use? ☐ No ☐ Yes If Yes, What Type? ☐ Cigarettes ☐ Cigars ☐ Oral Tobacco

Daily Amount: _____ # of years: _____ When did you quit? _____

Recreational drug use? ☐ No ☐ Yes If yes, please describe: _____

Patient Signature: _____ Date: _____

ALL PATIENTS ARE REQUIRED TO HAVE AN EMAIL ADDRESS ON FILE. IF YOU DO NOT HAVE AN EMAIL ADDRESS, PLEASE PROVIDE A FAMILY MEMBER OR FRIEND'S EMAIL ADDRESS. IT IS NOW AN INSURANCE REQUIRNMENT.

FAMILY MEDICAL HISTORY

	Father	Mother	Brother	Sister
Heart Attack	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐
Unsual Bleeding	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer (If so, what type?)	☐ _____	☐ _____	☐ _____	☐ _____
Other (describe):	☐ _____	☐ _____	☐ _____	☐ _____

PREVENTATIVE HEALTH MAINTENANCE

Please provide most recent date for each answer or right "none"

Last Mammogram:_____ Last Colonoscopy:_____

Last Prostate Exam:_____ Last Breast Biopsy:_____

Last Pap Smear:_____ Last Upper Endoscopy:_____

Last PSA Screening:_____ Last Bone Density Scan:_____

Allergies	Drug or Situation	(Please List the Type of Adverse Reaction)

Medications:	Drug Name	Dosage	How Often

REVIEW OF SYSTEMS

Please Check All That Apply to You:

☐ Weight Loss	☐ Loss of Appetite	☐ Coughing Up Blood	☐ Anxiety
☐ Fever	☐ Double Vision	☐ Wheezing	☐ Shortness of breath
☐ Night Sweats	☐ Blurred Vision	☐ Cough	☐ Diarrhea
☐ Weakness/Numbness	☐ Ear Pain	☐ Chest Pain	☐ Passing blood
☐ Headaches	☐ Throat Pain	☐ Leg Swelling	☐ Constipation
☐ Fainting	☐ Hoarseness	☐ Heartrate Fast/Slow	☐ Pain
☐ Dizziness	☐ Trouble swallowing	☐ Nausea	

PATIENT QUESTIONNAIRE

Please answer these questions to the best of your ability

1. **Have you ever had the Pneumonia Vaccine?** ☐ **Yes** ☐ **No** If so, When?_____ Where?_____
2. **Have you had a Flu Vaccine?** ☐ **Yes** ☐ **No** If so, When?_____ Where?_____
3. **Have you had a COVID Vaccine?** ☐ **Yes** ☐ **No** If so, When?_____ Where?_____
4. **Have you been on Hospice Care?** ☐ **Yes** ☐ **No** If so, When?_____ Where?_____
5. **BMI (BMI <20 Underweight, BMI 20-30 Normal, BMI >30 Overweight):**_____
6. **Do you currently live in a SNF (Skilled Nursing Facility) or Long-Term Facility?** ☐ **Yes** ☐ **No**
7. **Do you have a Power of Attorney?** ☐ **Yes** ☐ **No** *If yes, documentation must be provided*

AUTHORIZATION FOR USE OF DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby authorize _____ to disclose to Alabama Cancer Care, LLC. my medical records and information pertaining to my medical history, physical history, services rendered or treatment of including, if any, psychiatric or psychological information, infectious or contagious disease information, AIDS confidential information, and/or information about drug or alcohol abuse or treatment of the same.

Patient Name:_____ **Date of Birth:**_____

The purpose of this release is:

☐ To disclose the protected health information at my request

Other:_____

I authorize the below information to be disclosed on my behalf:

☐ Clinic Notes ☐ Discharge Summary ☐ X-ray Reports ☐ Pathology Reports ☐ Labs ☐ Other Reports

Any and all records from dates:_____ to _____

Patient Signature:_____ **Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By law, the HIPAA Privacy Rule prohibits Alabama Cancer Care, LLC. 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 the names of all persons that you wish to have access to your PHI (i.e. those making appointments or checking on test results for you):

1. **Name:**_____ **Relationship:**_____ **Phone Number:**_____
   Restrictions:_____
2. **Name:**_____ **Relationship:**_____ **Phone Number:**_____
   Restrictions:_____
3. **Name:**_____ **Relationship:**_____ **Phone Number:**_____
   Restrictions:_____

By signing below, I give Alabama Cancer Care, LLC. authorization to release my personal information as listed. I acknowledge that I have received the attached Notice of Privacy Practices:

Patient or Personal Representative Signature:_____ **Date:**_____

Print Patient or Personal Representative Name:_____

If Personal Representative's signature appears above, please describe relationship to the patient:_____

PATIENT ASSISTANCE INCOME AGREEMENT

As you know, treatment cost can be very expensive. If you need any type of infusion therapy or chemotherapy, you may owe copays or co-insurance based on your insurance policy. We will verify your insurance and let you know prior to treatment what your costs will be. We have several non-profit foundations which help patients with their costs when funding is available and will do our best to help you with funding. In doing so, we will need your information to fill out the applications. Please provide the following to allow us to assist you more efficiently.

Monthly Income of Household: $_____ **Number of Persons in Household:** _____

You may be asked to provide proof of income in some situations such as tax forms, bank statements, or social security statements. The foundations will often ask for these to verify that you need the assistance. Your information is kept secure and confidential and is only shared with the foundation when asked for. It will not be shared with any other entity without your permission. Upon signing this form, you give us permission to apply on your behalf and share this information to obtain financial assistance for treatment purposes only.

Patient Signature: _____ **Date:** _____

*If you are not willing to share this information and you wish to be responsible for all costs, please sign below as refusal:

Patient Signature: _____ **Date:** _____

RECEIPT OF INFORMATIONAL MATERIAL

ALABAMA CANCER CARE, LLC.
ACKNOWLEDGMENT OF RECEIPT OF ADVANCED DIRECTIVE MATERIALS

Alabama Cancer Care, LLC. ("ALCC") has, as required by the Patient Self-Determination Act, provided to me information concerning advance health care directives in the form of an information booklet (the "Booklet") on the date indicated below. I understand that the Booklet is provided for informational purposes only and describes in general terms the law and my rights with regard to advance health care directives.

I understand that the information contained in the Booklet is intended to serve only as a broad source of information on advance health care directives and the information is subject to change as the applicable law changes.

I acknowledge that I have received the information from ALCC regarding advance health care directives and agree that I have not received instructions from ALCC employees regarding completion of the advance health directive form, but have instead been advised to seek the counsel of my attorney or other advisor.

AGREED UPON AND ACKNOWLEDGED:

I have received the following information (please check all that apply):

- ☐ Advanced Directive Packet
- ☐ Pharmacy/Dispensary Pamphlet
- ☐ Patient Rights and Responsibilities Flyer

Patient Signature: _____ **Date:** _____

Print Patient Name: _____