



**Patient Welcome Letter**

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Dear Patient,

We have enclosed several forms that we ask you to complete and bring to your first visit. Completing these forms in advance will help save you time during the check-in process. We will also need you to bring the following with you to your visit:

- The included **forms**, completely filled out
- All **insurance cards** and information
- A driver’s license or any form of a **photo ID**
- Your actual **medication bottles** (not just a list) of the medications you are currently taking
- Any **co-pay** that is required by your insurance company at the time of your visit

We also ask that you try to arrive at least **thirty minutes prior** to your scheduled appointment time so that we can process your information and answer any questions you might have regarding our facility. It is very important that you keep your appointment. If for any reason you are unable to keep your appointment, please call as soon as possible so we may reschedule you in a timely manner. Your cooperation is greatly appreciated.

Our clinic hours vary by location, so please ask your Tennessee Cancer Specialists staff about the business hours of your clinic. There will always be medical personnel available after hours and on weekends for any emergency that may arise. Be assured that no matter whom you are treated by during non-office hours, the continuity of your care is always maintained under the direct supervision of your personal physician.

Our goal is always to provide you with professional and courteous service. We look forward to meeting and assisting you with all of your healthcare needs. Thank you for choosing Tennessee Cancer Specialists.

Sincerely,

Your physicians and staff at Tennessee Cancer Specialists



**HIPAA OMNIBUS RULE  
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Tennessee Cancer Specialists, through its individual physicians, employees, and or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by Tennessee Cancer Specialists.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Tennessee Cancer Specialists.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Tennessee Cancer Specialists. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by any physician and that the results of all tests will be kept confidential.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please **print** name of Patient

\_\_\_\_\_  
Please **sign** Patient / Guardian of Patient

\_\_\_\_\_  
Legal Representative / Guardian

\_\_\_\_\_  
Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:  
(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation     Home Phone Confirmation     Work Phone Confirmation  
 **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation     Home Phone Confirmation     Work Phone Confirmation  
 **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- Phone Message     Email     **Either**     **None** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment     I could not communicate with the patient     The patient refused to sign

- The patient was unable to sign because     Other (please describe) \_\_\_\_\_

Signature of Privacy Officer: \_\_\_\_\_

## New Patient Medical History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Primary Care Physician (PCP): \_\_\_\_\_

<p>Allergies:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Type of Reaction:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Pharmacy Name: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Current Medications:	Strength:	How Often Taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical History (Check all that apply):**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> COPD                          | <input type="checkbox"/> Gallstones         |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Reflux Disease                | <input type="checkbox"/> Hyperlipidemia     |
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Thyroid Disease         | <input type="checkbox"/> Kidney Stones                 | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Peripheral Neuropathy    | <input type="checkbox"/> Seizure                 | <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Cancer (please specify) _____ |   |
| <input type="checkbox"/> Arthritis                |  |  |   |

Other: \_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History - List all prior surgeries and date of occurrence:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GYN History:**

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Age at first birth \_\_\_\_\_  
 Age at first period \_\_\_\_\_ Date of last period (mm/dd/yyyy) \_\_\_\_\_  
 Any Hormone use? \_\_\_\_\_ If yes, for contraception or post-menopausal? \_\_\_\_\_ How many years? \_\_\_\_\_  
 \_\_\_\_\_ Last Mammogram (mm/dd/yyyy) \_\_\_\_\_ Last PAP (mm/dd/yyyy) \_\_\_\_\_



**Social History**

Marital Status: (Circle One)      Single              Married              Divorced              Widowed

Occupation: \_\_\_\_\_

**Tobacco Use:**    \_\_\_\_\_ **Never**

\_\_\_\_\_ **Yes, but quit**

How long did you smoke? \_\_\_\_\_

What form of tobacco did you use? Please mark all that apply:

\_\_\_ Cigarettes    \_\_\_ Cigars              \_\_\_ Chewing Tobacco    \_\_\_ Pipe              \_\_\_ Snuff

How many packs per day? \_\_\_\_\_

When did you quit? \_\_\_\_\_

\_\_\_\_\_ **Yes, Active**

How long have you smoked? \_\_\_\_\_

What form of tobacco do you use? Please mark all that apply:

\_\_\_ Cigarettes    \_\_\_ Cigars              \_\_\_ Chewing Tobacco    \_\_\_ Pipe              \_\_\_ Snuff

How many packs per day? \_\_\_\_\_

**Alcohol Use:**    \_\_\_\_\_ **Never**

\_\_\_\_\_ **Yes, Occasional**

\_\_\_\_\_ **Yes, Active**

How many days per week do you drink? \_\_\_\_\_

How many drinks per day? \_\_\_\_\_

\_\_\_\_\_ **Yes, but quit**

How many days per week do you drink? \_\_\_\_\_

How many drinks per day? \_\_\_\_\_

How many years since you quit? \_\_\_\_\_

Have you ever used any recreational or illicit drugs?    \_\_\_ Yes              \_\_\_ No

**Hazardous Materials: Check if you have been exposed to any of the following:**

\_\_\_\_\_ Asbestos              \_\_\_\_\_ Benzene              \_\_\_\_\_ Lead              \_\_\_\_\_ Radiation

\_\_\_\_\_ Other Petroleum Products              \_\_\_\_\_ Other (please specify): \_\_\_\_\_

**Family History**

**Please list any major medical problems and/or causes of death in your immediate family:**

<b>Family Member</b>		<b>Current Age</b>	<b>Age at Death</b>	<b>Major Medical Problems</b>
Mother:	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Maternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Maternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Paternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Paternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____

**Children / Age(s)** \_\_\_\_\_

Any major medical problems? \_\_\_\_\_  
\_\_\_\_\_

Any additional information that your doctor may need to know:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

Date: \_\_\_\_\_  
Date of visit

Name: \_\_\_\_\_

Phone# \_\_\_\_\_

Date: \_\_\_\_\_

**Review of Systems**

Chief Complaint: Why are you here **today**? \_\_\_\_\_

**Please mark if you are having any of the following symptoms:**

<p><b><u>General</u></b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weakness <input type="checkbox"/> Weight Loss <input type="checkbox"/> _____	<p><b><u>Skin</u></b></p> <input type="checkbox"/> Chronic Sores <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> _____	<p><b><u>HEENT</u></b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sinus Problems <input type="checkbox"/> _____	<p><b><u>Neck</u></b></p> <input type="checkbox"/> Neck Pain <input type="checkbox"/> Palpable Lumps <input type="checkbox"/> _____
<p><b><u>Respiratory</u></b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> _____	<p><b><u>Cardiovascular</u></b></p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fainting or passing out <input type="checkbox"/> Palpitations <input type="checkbox"/> _____	<p><b><u>Gastrointestinal</u></b></p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> _____	<p><b><u>Genitourinary</u></b></p> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Increased Frequency <input type="checkbox"/> Painful Urination <input type="checkbox"/> Urgency <input type="checkbox"/> _____
<p><b><u>Musculoskeletal</u></b></p> <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> _____	<p><b><u>Neurologic (CNS)</u></b></p> <input type="checkbox"/> Change in Speech <input type="checkbox"/> Headache <input type="checkbox"/> Numbness in Fingers <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizure <input type="checkbox"/> Sensory symptoms <input type="checkbox"/> Tremors <input type="checkbox"/> _____	<p><b><u>Psychological</u></b></p> <input type="checkbox"/> Agitation <input type="checkbox"/> Anxiety <input type="checkbox"/> History of or current feelings of depression <input type="checkbox"/> Suicidal or Homicidal thoughts <input type="checkbox"/> _____	<p><b><u>Hematology</u></b></p> <input type="checkbox"/> Blood Clots <input type="checkbox"/> Prolonged Bleeding or Bruising <input type="checkbox"/> _____
<p><b><u>Endocrinology</u></b></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid problems <input type="checkbox"/> _____			

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_