TENNESSEE CANCER
SPECIALISTS

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Patient Appointed _____ Time _____ Physician _____

Patient Welcome Letter

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

For TCS use only: **Appt. Date and Time: _____ Account # _____Physician _____**

Tennessee Cancer Specialists
Patient Information

Email Address: _____

Name: _____
First Middle Initial Last

Date of Birth: _____ Social Security #: _____ Sex: (circle): M F

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work/Cell: (____)_____ May we leave a message on this number? Y N

Employer: _____ Employer Phone Number: (____)_____

Primary Care Physician: _____ Physician That Referred You to TCS: _____

Primary Language (circle): English Spanish Other _____ Marital Status (circle): M S W D

Ethnicity (circle): Caucasian Hispanic US Black Unknown Other: _____

Race (circle): White Hispanic or Latino African American Asian Other: _____

Insurance Information

Primary Insurance

Insurance Co. _____

Insurance ID #_____

Group #_____ Effective Date _____

Policy Holder's Name _____

Relationship to Policy Holder _____

Policy Holder's Date of Birth _____

Policy Holder's SS# _____

Policy Holder's Employer _____

Secondary Insurance

Insurance Co. _____

Insurance ID #_____

Group #_____ Effective Date _____

Policy Holder's Name _____

Relationship to Policy Holder _____

Policy Holder's Date of Birth _____

Policy Holder's SS# _____

Policy Holder's Employer _____

Emergency Contact Information

1. Name: _____ Relationship: _____ Phone Number: _____
2. Name: _____ Relationship: _____ Phone Number: _____

One Time Authorization

*****Please Initial All Four Lines*****

I authorize the release of any medical information necessary to process insurance claims filed on my behalf _____

I authorize payment of medical benefits to be made directly to the supplier or physician for services performed _____

I acknowledge that I will be responsible for any balance after insurance(s) has paid _____

I understand that it is my responsibility to notify the office of any changes or deletions to my insurance(s) policy _____

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 herby 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: _____

Revised 1.1.15

TENNESSEE CANCER SPECIALISTS

New Patient Medical History Form

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

Reason for Referral: _____

Allergies:	**Type of Reaction:**
_____	_____
_____	_____
_____	_____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

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

Past Medical History (Check all that apply):

____ Asthma	____ Diabetes	____ Hepatitis	____ Anxiety
____ Depression	____ Atrial Fibrillation	____ COPD	____ Gallstones
____ Congestive Heart Failure	____ Coronary Artery Disease	____ Reflux Disease	____ Hyperlipidemia
____ Hypertension	____ Thyroid Disease	____ Kidney Stones	____Osteoporosis
____ Peripheral Neuropathy	____ Seizure	____ Stroke	____ Bleeding Disorders
____ Kidney Disease	____ Glaucoma	____ Cancer (please specify) _____	
____ 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)_____

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Patient Name: _____

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): _____

TENNESSEE CANCER SPECIALISTS

Patient Name: _____

Family History

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

Family Member		Current Age	Age at Death	Major Medical Problems
Mother:	____Alive ____Deceased	_____	_____	_____
Maternal Grandmother	____Alive ____Deceased	_____	_____	_____
Maternal Grandfather	____Alive ____Deceased	_____	_____	_____
Father	____Alive ____Deceased	_____	_____	_____
Paternal Grandmother	____Alive ____Deceased	_____	_____	_____
Paternal Grandfather	____Alive ____Deceased	_____	_____	_____
Brother Sister (circle)	____Alive ____Deceased	_____	_____	_____
Brother Sister (circle)	____Alive ____Deceased	_____	_____	_____

Use back if additional room needed.

Children / Age(s)_____

Any major medical problems?_____

_____

Any additional information that your doctor may need to know:

_____
_____
_____
_____

_____ Date: _____

Patient Signature Date of visit

New Patient Review of Systems

Name: _____ **Date: _____**

Chief Complaint: Why are you here today?

_____

_____

Have had a flu shot this year? (circle one) Yes No

Have you had a Colonoscopy or a Flexible Sigmoidoscopy before? (circle one) Yes No
If yes, when? _____

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

Constitutional	**Eyes**	**ENMT**	**Endocrine**
☐ Appetite ☐ Fatigue ☐ Night Sweats ☐ Rigors/Chills ☐ Fever ☐ Weight loss ☐ Weight Gain ☐ >10 lbs ☐ <10 lbs	☐ Blurred Vision ☐ Double Vision ☐ Eye Pain	☐ Trouble Swallowing ☐ Ear Pain ☐ Nose Bleeds ☐ Loss of Hearing ☐ Mouth Dryness ☐ Oral Bleeding ☐ Sinusitis ☐ Mouth Sores ☐ Taste Altered ☐ Ringing in Ears	☐ Hot Flashes ☐ Cold Intolerance
Hematologic/Lymphatic	**Breast**	**Respiratory**	**Cardiovascular**
☐ Prolonged Bleeding or Bruising ☐ Swollen Lymph Nodes or Glands	☐ Breast Mass ☐ Nipple Discharge ☐ Skin Changes ☐ Breast Pain	☐ Cough ☐ Shortness of Breath ☐ Coughing up Blood ☐ Hiccoughs ☐ Wheezing	☐ Chest Pain ☐ Palpitations ☐ Leg or Ankle Swelling
Gastrointestinal	**Genitourinary Female**	**Genitourinary Male**	**Musculoskeletal**
☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Blood in Stool	☐ Painful Urination ☐ Frequency-Increased Urination ☐ Blood in Urine ☐ Urine Color Change ☐ Vaginal Discharge/ Bleeding	☐ Painful Urination ☐ Frequency-Increased Urination ☐ Blood in Urine ☐ Urine Color Change	☐ Joint Pain ☐ Muscle Weakness ☐ Joint Swelling ☐ Bone Pain
Integumentary	**Neurologic**	**Psychiatric**	**Other**
☐ Blisters ☐ Dry Skin ☐ Itching ☐ Rash ☐ Hair Loss	☐ Dizziness ☐ Headache ☐ Insomnia ☐ Memory loss ☐ Paralysis ☐ Seizure ☐ Numbness/Tingling	☐ Hallucinations ☐ Depression ☐ Anxiety	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____