Patient Appointment ____________________________ Time _________ Physician _______________________

Russell F. Devore III, MD
Tracy W. Dobbs, MD
Sudarshan Doddabele, MD
Saji Eapen, MD
Yi Feng, MD
Hesamm Gharavi, MD
Daniel Ibach, MD
Ross E. Kerns, MD
Richard T. Lee, MD
Mitchell D. Martin. MD
Dharmen Patel, MD
R. David Schumaker, MD
Anil V. Tumkur, MD

Jennifer Berry, ANP-BC
Lainey Briggs, OCN, FNP-BC
Stephanie Carroll, APRN-BC
Beth Clayton, FNP
Ashley Davis, FNP-BC
Jeanine Dople, FNP
Sheryl Freese, FNP, AOCNP
Molly Gibson, APRN, FNP-BC
Deborah Graf, FNP
Kim Hoyle, APRN, FNP-BC
Leslie Lane, OCN, FNP-BC
Christine Leslie, FNP-BC
Amy Neil, OCN, ANP-BC
Jennifer Pickwell, OCN, ANOP
Kathryn Shelton, FNP-BC
Tiffany Sipe, FNP-BC
James Wolfenbarger, FNP-BC
Brittany Wright, FNP
Jim Young, FNP-BC

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
- ☐ Copy of living will or power of attorney

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

Administrative Office: 900 East Hill Ave., Suite 230, Knoxville, TN, 37915
Phone: 865-862-0998 Fax 865-544-1861
www.tncancer.com

For TCS use only: **Appt. Date and Time: ____________________** **Account # ____________________** **Physician ___________________**

Tennessee Cancer Specialists
Patient Information

How did you hear about our practice?____

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 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: _______________________

Do you have a living will? ______

Do you have a medical power of attorney? ______

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*** for 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: ____________________ Phone: ___________________

Name: __________________________ Relationship: ____________________ Phone: ___________________

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 2.19.18

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)________________

TENNESSEE CANCER SPECIALISTS

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

Date: ___________________ Name: __________________________

New Patient Review Of Systems

Chief Complaint: Why are you here **today**? ____

Have you had a **Flu shot** this year? (circle one) YES NO

Have you had any recent **CT scans, MRI's, PET scans, X-Rays, ER Visits**, etc.? (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 Good ☐ Appetite Poor ☐ Fatigue ☐ Night Sweats ☐ Rigors/Chills ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ >10 lbs ☐ <10 lbs ☐ Weakness ☐ Sleep Disturbance	☐ Blurred Vision ☐ Double Vision ☐ Eye Pain	☐ Trouble Swallowing ☐ Ear Pain ☐ Nose Bleeds ☐ Hearing Loss ☐ Dry Mouth ☐ Oral Bleeding ☐ Sinusitis ☐ Mouth Sores ☐ Altered Taste ☐ Ringing In Ears	☐ Hot Flashes ☐ Cold Intolerance
Hematologic/Lymphatic	**Breast**	**Respiratory**	**Cardiovascular**
☐ Prolonged Bleeding or Bruising ☐ Swollen Lymph Nodes or Glands	☐ Breast Mass L or R ☐ Breast Pain L or R ☐ Nipple Discharge L or R ☐ Skin Changes L or R	☐ Dry Cough ☐ Productive Cough ☐ Shortness Of Breath ☐ At Rest ☐ With Activity ☐ Coughing Up Blood ☐ Hiccups ☐ Wheezing	☐ Chest Pain ☐ Palpitations ☐ Leg or Ankle Swelling ☐ Left ☐ Right
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**	**Are you having any pain today? Please check:**
☐ Blisters ☐ Dry Skin ☐ Itching ☐ Rash ☐ Hair Loss	☐ Dizziness ☐ Headache ☐ Insomnia ☐ Memory loss ☐ Paralysis ☐ Seizures ☐ Numbness/Tingling **Location** ____________	☐ Hallucinations ☐ Depression ☐ Anxiety	**__ 0 (no pain)** **__ 1 __ 6** **__ 2 __ 7** **__ 3 __ 8** **__ 4 __ 9** **__ 5 __ 10** **Location** _________________

Revised 12/2018