ADVOCATE
Radiation Oncology, LLC

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

# PATIENT REGISTRATION

**PLEASE COMPLETE ALL ENTRIES**

| PATIENT NAME<br>Last Name ______________________<br>First Name ______________ MI _____ | | ADDRESS<br>Street ______________________<br>City ______________ State ________ ZIP ______ | |
|---|---|---|---|
| Email | HOME PHONE | CELL PHONE | Is iPhone<br>☐ No ☐ Yes |
| PATIENT DATE OF BIRTH | PATIENT SSN | Gender<br>Male ☐ Female ☐ | MARITAL STATUS<br>☐ Single ☐Married ☐ Other__________ |
| PATIENT EMPLOYER NAME | | PATIENT EMPLOYER ADDRESS<br>Street ______________________<br>City ____________ State ______ ZIP ______ | EMPLOYER PHONE |

| INSURED/RESPONSIBLE PARTY INFORMATION | | RELATION TO PATIENT: ☐ spouse ☐ parent ☐ guardian | | |
|---|---|---|---|---|
| NAME<br>Last Name ______________<br>First Name ____________ MI __ | | ADDRESS<br>Street ______________________ City ____________<br>State ______ ZIP ______ | | |
| HOME PHONE | WORK PHONE | SSN | BIRTH DATE | EMPLOYER |

**INSURANCE INFORMATION**

| PRIMARY INSURANCE NAME | | ADDRESS (from the back of the insurance card)<br>Street ______________________ City ____________<br>State __________ ZIP ______ | | | |
|---|---|---|---|---|---|
| GROUP NUMBER | ID NUMBER | HMO<br>☐ | PPO<br>☐ | | INSURANCE PHONE |
| SECONDARY INSURANCE NAME | | ADDRESS (from the back of the insurance card)<br>Street ______________________ City ____________<br>State __________ ZIP ________ | | | |
| GROUP NUMBER | ID NUMBER | HMO<br>☐ | PPO<br>☐ | | INSURANCE PHONE |

| PRIMARY DOCTOR/FAMILY DOCTOR | REFERRING DOCTOR | |
|---|---|---|
| IN CASE OF EMERGENCY CONTACT | RELATIONSHIP | PHONE NUMBER |

**Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?**
**Yes ☐ No ☐ If yes please fill out the following:**

**Facility Name: ______________________________ Phone: ____________________**

**Address: __________________________ City: ________________ State:__________ Zip _________**
**Are you receiving benefits from the Veterans Administration?**
**Yes ☐ No ☐ If yes please fill out the following:**

**VA Name: ______________________________ Phone: ____________________**

**Address: __________________________ City: ________________ State:__________ Zip _________**

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**Which of the following best describe your race?**

☐ **Asian** ☐ **Caucasian** ☐ **Black / African American** ☐ **Hispanic**

☐ **Subcontinent Asian American** ☐ **Asian Pacific American** ☐ **Native American**

☐ **American Indian / Alaskan Native** ☐ **Hawaiian** ☐ **Pacific Islander**

☐ **More than one race** ☐ **Other** ☐ **Decline**

**Please select one ethnic group that best describes your race**

☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino**

☐ **Decline** ☐ **Don’t know**

**What language do you feel most comfortable using when discussing your healthcare?**

☐ **English** ☐ **Spanish** ☐ **German** ☐ **French**
☐ **Chinese**

☐ **Italian** ☐ **Russian** ☐ **Portuguese**

☐ **Other** ☐ **Decline** ☐ **Don’t know**

**how often do you use internet for gathering information?**

☐ **Always** ☐ **Usually** ☐ **Sometimes** ☐ **Never**

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Physician: ______________________

# Medical History Forms

**Cancer Diagnosis or reason for consultation:** ________________________________________________________

## Past Medical History *(Please check all that apply)*

☐ Allergies
☐ COPD
☐ High blood pressure
☐ Anxiety
☐ Depression
☐ Inflammatory Bowel Disease (Crohn's disease, colitis, etc)
☐ Anemia/Blood Disorder
☐ Diabetes
☐ Migraines/headaches
☐ Arthritis
☐ Diverticulitis
☐ Neuropathy
☐ Asthma
☐ Erectile dysfunction
☐ Psychosis
☐ Atrial fibrillation/irregular heartbeat
☐ Fibromyalgia
☐ Rheumatoid Arthritis
☐ Autoimmune disorder (lupus, scleroderma, RA, etc)
☐ GERD
☐ Seizures
☐ Bipolar Disorder
☐ Gout
☐ Stroke
☐ Blood clots or pulmonary embolism
☐ Heart Attack
☐ Thyroid Disorder
☐ BPH (prostate)
☐ Heart Disease
☐ Tremors
☐ CAD (coronary artery disease)
☐ High cholesterol
☐ Osteoporosis

☐ Cancer, prior history ______________________________________________________________________________

☐ Infectious disease (HIV, hepatitis, Tuberculosis, etc)? __________________________________________________

☐ Other ___________________________________________________________________________________________

**Have you ever received radiation therapy?** No ____ Yes _____ If yes, when? _____________________________

Physician's Name/Facility: ______________________________________________________________________
Address: ______________________________________________________________________________________
What area was treated? ________________________________________________________________________

**Have you ever received chemotherapy?** No ____ Yes ____ If yes, when? _________________________________
Physician's Name/Facility: ______________________________________________________________________
Address: ______________________________________________________________________________________

ADVOCATE Radiation Oncology, LLC

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Physician: ______________________

## Past Surgeries *Please list surgery, year of operation, surgeon and location (if known)*

| Procedure/Operation | Date | Physician | Location |
|---|---|---|---|
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Do you have any implanted medical devices such as a **PACEMAKER, DEFIBRILLATOR**, neurostimulator, drug infusion pumps, etc? ☐ **No** ☐ **Yes** *If yes, please provide copy of your medical device card to front desk*.

## Allergies

Are you allergic to any medications? ☐ **No** ☐ **Yes** If **yes**, name/reaction: ________________________________
______________________________________________________________________________________________

Are you allergic to latex? ☐ No ☐ Yes If yes, reaction: ________________________________________
Are you allergic to IV Contrast? ☐ No ☐ Yes If yes, reaction: ________________________________________
Others (food, tape, environmental, etc.) ______________________________________________________________

## Medications

**Pharmacy Name: ________________________________Pharmacy Number: ____________________________**

**Pharmacy Address: ____________________________________________________________________________**

| Medication | Dose | Frequency | Prescribing Physician |
|---|---|---|---|
| | | | |
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*Please use back of this form if you need additional room for medications*

ADVOCATE Radiation Oncology, LLC

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

## Family History

**Father:** if living, age __________ if deceased, age at death: _______________

Medical Problems ___________________________________________________________________________________________

**Mother:** if living, age __________ if deceased, age at death: _______________

Medical Problems ___________________________________________________________________________________________

**Siblings:** # of Females __________ # of Males _______________

Medical Problems/Deceased ____________________________________________________________________________________

______________________________________________________________________________________________________________

**Children:** # of Females __________ # of Males _______________

Medical Problems/Deceased ____________________________________________________________________________________

## Social History

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse or significant other's name: ____________________________________________________________

**Social Geographic history:**

Where were you born? _________________________________________________________________

Where did you live most of your life? ______________________________________________________

Do you live in this state all year round? ☐ **No** ☐ Yes

If **no**, please provide your alternate address: ____________________________________________

City: _____________________________ State: __________________ Zip: ______________

**Occupation/Service History:**

Occupation: ___________________________________ ☐ Retired ☐ Disabled, reason? _______________

Have you served in the military? ☐ No ☐ Yes

To your knowledge, have you ever worked in an occupation that involved exposure to asbestos or other cancerous chemicals, fumes, or carcinogens? ☐ No ☐ **Yes**

**If yes, describe:** _________________________________________________________________________

**Substance History:**

Have you ever smoked? ☐ No ☐ **Yes** If **yes,** what? ☐ Cigarettes ☐ Cigars ☐ Pipe

How many years? _____________________ Packs/number per day? ____________________________

If **yes**, have you quit? ☐ No ☐ **Yes** If **yes**, when? ________________________________________

Have you ever chewed tobacco? ☐ No ☐ Yes How much? __________________________________

If yes, have you quit? ☐ No ☐ **Yes** If **yes,** when? ____________________________________________

Do you drink alcoholic beverages? ☐ No ☐ **Yes**

If **yes**, how often and how much? _______________________________________________________

Have you quit drinking? ☐ No ☐ **Yes** If **yes,** when? ____________________________________

Have you or do you use street drugs? ☐ No ☐ **Yes**

If **yes**, describe ___________________________________________________________________________

ADVOCATE Radiation Oncology, LLC

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## Preventative Health Maintenance

**Female**: Last mammogram: ________________
Last pap smear: __________________
Last colonoscopy: _________________
Last bone density scan: ____________
Last pneumonia vaccine: ___________
Last influenza (flu) shot: ____________

**Male**: Last PSA screening: _______________
Last prostate exam: _______________
Last colonoscopy: _________________
Last bone density scan: ____________
Last pneumonia vaccine: ___________
Last influenza (flu) shot: ____________

## Mobility Risk Assessment

1. Do you need assistance walking? ☐ **No** ☐ **Yes** If **yes,** do you use a ☐cane ☐ walker ☐ wheelchair?
2. Have you fallen before or been injured because of a fall? ☐ **No** ☐ **Yes**
3. Do you feel weaker than you used to or have less strength in your arms or legs? ☐ **No** ☐ **Yes**
4. Have you stopped or avoided exercise/daily activities because of a fear of falling? ☐ **No** ☐ **Yes**
5. Do you have foot ulcers, bunions, hammertoes, or calluses that hurt or cause you to adjust your steps? ☐ **No** ☐ **Yes**
6. Do you feel dizzy when you stand up? ☐ **No** ☐ **Yes**
7. How many falls have you had in the last 12 months? _____________
8. Did you suffer an injury from you falls? ☐ **No** ☐ **Yes** If **yes**, please explain: ____________________________

### Females Only

1. Age at first menstrual period: ______________
2. Do you still have periods? ☐ No ☐ Yes
3. Date or Age of last menstrual period: ________
4. Age at first pregnancy: ____________________
5. Number of pregnancies: ____________________
6. Number of births: ________________________
7. Did you breastfeed? ☐ No ☐ Yes
8. Have you ever taken hormone replacement therapy? ☐ No ☐ Yes
9. If yes, how many years? ________________

### Pain Assessment

Do you have pain now? ☐ **No** ☐ **Yes** If **yes**, please answer the following questions.
Where is your pain located? __________________________________________________________________
On a scale of 1-10, with 1 being very mild and 10 being the worst pain imaginable, what number is your pain?
**1**☐ **2** ☐ **3**☐ **4** ☐ **5**☐ **6** ☐ **7**☐ **8** ☐ **9**☐ **10**☐
How would you describe the pain? (e.g. aching, stabbing, burning, throbbing, sharp, dull) ________________
When did your pain start? _____________________________________________________________________
Does anything make it better or worse? _________________________________________________________
Are you taking pain medications? ☐ No ☐ **Yes** If **yes**, what? ___________________________________________

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Physician: ______________________

# Review of Systems

***Have you recently experienced any of these symptoms? Please select all that apply:***

**General**
☐ Fever/Chills
☐ Fatigue
☐ Weight loss/gain ______ lbs

**Eyes and Vision**
☐ Glasses/contacts
☐ Eye disease or injury
☐ Eye pain or pressure
☐ Blurred or Double vision

**Ears, nose, throat**

☐ Hearing loss
☐ Ringing in ears
☐ Ear ache or drainage
☐ Sinus problems
☐ Nose bleeds
☐ Dental problems
☐ Dentures
☐ Mouth sores
☐ Sore throat
☐ Difficulty/painful swallowing
☐ Hoarseness or voice change
☐ Swollen glands in neck

**Heart/Cardiovascular**

☐ Chest pain
☐ Heart Palpitations
☐ Dizziness
☐ Swollen legs/ankles

**Respiratory**
☐ Frequent Coughing
☐ Spitting up blood
☐ Wheezing or asthma
☐ Shortness of breath

**Endocrine**
☐ Loss of hair/thinning hair
☐ Heat/cold intolerance
☐ Excessive thirst

**Gastrointestinal**

☐ Loss of appetite
☐ Nausea or Vomiting
☐ Stomach pain
☐ Frequent diarrhea
☐ Constipation
☐ Blood in stool

**Genitourinary**

☐ Frequent urination
☐ Burning or painful urination
☐ Blood in urine
☐ Incontinence or dribbling
☐ Urgency
☐ Vaginal discharge
☐ Painful/irregular periods
☐ Sexual difficulty

**Psychiatric**
☐ Depression
☐ Anxiety/Nervousness
☐ Sleep Disorders
☐ Suicidal Thoughts

**Hematology/lymphatic**
☐ Easily bruise or bleed
☐ Anemia
☐ Slow to heal
☐ History of transfusion

**Musculoskeletal**

☐ Joint pain or stiffness
☐ Back pain
☐ Muscle pain or cramps
☐ Cold arms or legs
☐ Difficulty walking

**Skin and Breast**

☐ Rash or Itching
☐ Lesion or change in skin color
☐ Breast mass/lump
☐ Nipple discharge / retraction
☐ Open or non-healing wound

**Neurological**

☐ Frequent headache
☐ Lightheaded or dizzy
☐ Confusion
☐ Speech difficulty
☐ Seizure activity
☐ Numbness or tingling
☐ Weakness in arms or legs

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Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

**Advance Directives:**

Do you have a Medical Power of Attorney: ☐ **Yes** ☐ **No** Do you have a Living Will**:** ☐ **Yes** ☐ **No**

Do you have and Advance Directive? ☐ **Yes** ☐ **No** Do you have a donor card? ☐ **Yes** ☐ **No**

**If you answered 'yes' to any of the above questions. Please provide a copy of the document**

**Please list the names and addresses of Physicians you would like correspondence sent to:**

______________________________________________ ______________________________________________
Physician name and phone Physician name and phone

______________________________________________ ______________________________________________
Physician name and phone Physician name and phone

As the patient you acknowledge with the completion of this form it constitutes your complete clinical history summary

Patient Signature __________________________________________ Date _____________________________

Nurse Signature ___________________________________________ Date: _____________________________

Physician Signature ________________________________________ Date _____________________________

ADVOCATE
Radiation Oncology, LLC

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

# Assignment of Benefits

## Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service,
Unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

## Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Advocate Radiation Oncology LLC medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## Authorization to Release Information

I hereby authorize Advocate Radiation Oncology LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Advocate Radiation Oncology LLC on behalf of myself and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

___________________________________ _________________
Patient / Responsible Party Signature Date

___________________________________ __________________
Witness Date

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

# HIPAA Patient Disclosure Form for Health Information

## ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at Advocate Radiation Oncology. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.
The Health Insurance Portability & Accountability Act of 1996 S160.103, also known as HIPAA, defines individual personal health information (PHI) as information, including demographic information collected from an individual and to include information that is:
1. Created or received by a health care provider, health plan, employer, or healthcare clearing house.
2. Related to the past, present or future physical, mental health and/or condition of an individual past, present or future payment for provision of health care to an individual.
3. The information, therefore, that identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.
The PHI can only be disclosed through a permitted disclosure (S164.502) and used by a health care provider in the following manners:

1. For treatment: We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
2. For payment: We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
3. For health care operations: We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

2. Uses or disclosure to a personal representative assigned by patient.
3. Disclosure to the parents or persons acting in loco to parents to unemancipated minor.
4. For case management, care coordination for the individual, to direct or recommend alternative treatments or therapies, health care providers or health care selling.

ADVOCATE
Radiation Oncology, LLC

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

I ___________________________________________am a patient of Advocate Radiation Oncology LLC and understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time by myself. This disclosure becomes effective the date it is signed and will continue until it is cancelled, changed, altered or amended by myself or my appointed legal representative. This facility has notified me that they have a listing of all the persons and agencies or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility.
I HAVE READ THE PERMITTED DISCLOSURE FORM AND I UNDERSTAND IT.
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature ______________________ Date ________ Signature of Witness ________________________

If Individual is unable to sign this Authorization, please complete the information below:

| ___________________________ | _________________ | ______ | ___________ |
|---|---|---|---|
| Name of Guardian/ Representative | Legal Relationship | Date | Witness |

I do hereby authorize the following to access my medical information at any time:

Name: ________________________________ Name: ______________________________

Relationship: _________________________ Relationship: _________________________

Phone Number: _______________________ Phone Number: _______________________

Address: _____________________________ Address: _____________________________

Name: ________________________________ Name: ______________________________

Relationship: _________________________ Relationship: _________________________

Phone Number: _______________________ Phone Number: _______________________

Address: _____________________________ Address: _____________________________

Patient Signature: __________________________________________________ Date: _________________

Witness Signature: _________________________________________________ Date: _________________

ADVOCATE
Radiation Oncology, LLC

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

# Medical Records Release Form

Patient Name: ______________________________________________________________________________
Date of Birth: __________________________________Phone:________________________________________
Address: __________________________________________________________________________________
City: ________________________________________State:________________Zip: ______________________

1. *I authorize the use or disclosure of the above-named individual's health information as described below:*
2. *The following individual or organization is authorized to make the disclosure:*

Name: ____________________________________________________________________________________
Address: __________________________________________________________________________________
City: ____________________________________State: _______________Zip: ___________________________

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

____ All medical records
____ Consultation Reports
____ Dosimetry / Physics
____ Lab results/X-ray reports
____ Progress Notes
____ Follow up
____ Other (Please specify) ________________________________________________________________

4. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to and used by the following individual or organization.*
Name: **Advocate Radiation Therapy LLC**

☐ Port Charlotte
3080 Harbor Blvd.
Port Charlotte, FL 33952
Tel: (941) 883-2199
Fax: (941) 979-5041

☐ Fort Myers
15681 New Hampshire Ct.
Fort Myers, FL 33908
Tel: (239) 437-1977
Fax: (239) 437-1889

☐ Cape Coral
909 Del Prado Blvd. S
Cape Coral, FL 33990
Tel: (239) 217-8070
Fax: (239) 217-8069

☐ Tamarac
7850 N. University Dr.
Tamarac, FL 33321
Tel: (754) 205-0099
Fax: (954) 388-5849

☐ Bonita Springs
25243 Elementary Way
Bonita Springs, FL 34135
Tel: (239) 317-2772
Fax: (239) 676-7637

*For the purpose of:* ____________________________________________________________________

ADVOCATE
Radiation Oncology, LLC

Date: __________
Patient Name: ______________________
Medical ID Number: ______________________
Physician: ______________________

6. I understand that I have a right to revoke this authorization at any time. I understand that is I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, **this authorization will expire on the following date, event, or condition**:

______________________________________________________________________________________________

7. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact a clinic representative at any of the Advocate Radiation Oncology locations.

| ______________________________ | __________________________________________ | ____________ |
|---|---|---|
| Signature of patient or legal representative | Printed name of representative and relationship to patient | Date |

**PLEASE NOTE:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law and federal law.