

Patient Information Form

Name of Patient: _____ Date of Birth: _____ Age: _____

Home Address: _____ County: _____

City, State, Zip: _____

Mailing Address (if different): _____

Home Phone: (____) _____ Cell:(____) _____ Work:(____) _____

Email Address: _____

Social Security Number: _____ Sex: Male Female

Marital Status: Single(Never Married) Married Life Partner Divorced/Separated Widowed

Race: African American or Black Asian Hispanic White American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander Other _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Preferred Language: English Spanish Other _____

Employment Status: Full Time Part Time Not Employed Active Military Retired Military
 Self Employed Disabled Retired, date of Retirement: _____

Employer and Address: _____

Insurance Information:

Primary Insurance Co. _____ ID: _____

Secondary Insurance Co: _____ ID: _____

ADDITIONAL INFORMATION NEEDED FOR PROCESSING OF INSURANCE:

Do you have employer group health coverage? Yes No If yes, are you still working? Yes No

Are you covered through your spouse's insurance? Yes No If yes, their date of birth: ____/____/____

Does his/her employer have more than 50 employees Yes No Is your spouse still working? Yes No

Are you a resident of a skilled nursing facility? Yes No If yes, answer the next facility questions.

Name of Facility _____ Facility Address: _____

Facility Phone Number: _____ Does insurance pay for the stay? Yes No

Prescription Drug Coverage:

Do you have prescription drug coverage? Yes No If yes, please list below and provide a copy to us.

Prescription Drug Insurance Carrier _____

Pharmacy:

Pharmacy: _____ Pharmacy Location: _____

Pharmacy Phone: _____

Patient Name: _____

Date of Birth: _____

AUTHORIZATIONS AND CONSENT

Authorization to pay benefits to the physician: I hereby authorize payment directly to Carolina Oncology Specialists, PA for any services furnished to me by this provider. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid directly to me.

Person responsible for payment if patient is unable to pay:

Name: _____ Relation: _____ Phone # _____

Consent for purposes of treatment, payment and healthcare operations: I hereby consent to treatment by Carolina Oncology Specialists, PA. I also consent to the use or disclosure of my protected health information by COS for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of COS. I understand that diagnosis and/or treatment may be conditional upon consent.

Acknowledgment of Receipt of Notice of Privacy Practices: I have received a copy of Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

ADVANCED PRACTITIONER (NP/PA) CONSENT

Carolina Oncology Specialists, PA utilizes Physician Assistant's and Nurse Practitioner's in our office for the levels of our practice that have been approved by the North Carolina State Board of Medical Examiners.

I confirm my agreement to being treated by a Physician Assistant or Nurse Practitioner who is under the supervision of the physicians with Carolina Oncology Specialists, PA, by signing below.

Patient Signature: _____ **Date:** _____

AUTHORIZATION TO PROVIDE CONTRACTED SERVICES

During your care at Carolina Oncology Specialists, PA, your physician may prescribe medications. You have the option of receiving these services from the dispensary/pharmacy of your choice.

Dispensary Services

Carolina Oncology Specialists, PA could provide you with many prescribed medications through Carolina Oncology Specialists, PA, a dispensary in which the physician owners have an investment interest. These medications may be dispensed by your physician and transferred to you if you desire. If needed, a pharmacist/physician is available to provide you with counseling concerning your medications.

In addition to Carolina Oncology Specialists, PA, there are local pharmacies in the area that may fill your prescription. A few of the providers in this area are listed below. This is not a complete list of options.

CVS: 704.542.9210

Walgreen's: 704-367-1716

Harris Teeter: 704.364.1245

I understand that I have an option of receiving my prescriptions from the provider of my choice.

Patient Signature: _____ **Date:** _____



Patient Name: _____
 Date of Birth: _____

HIPAA Information

I do not authorize Carolina Oncology Specialists, PA to communicate with anyone other than me, excluding all disclosures allowed by law.

OR

I have agreed to let certain individual(s) participate in discussion and decisions related to my medical care. Therefore, I hereby give permission for Carolina Oncology Specialists, PA and staff to disclose my personal information (in person, by telephone, by fax and/or by mail) to the following individual(s):

*Primary Contact: _____ *Relationship: _____

*Phone: _____

Additional Names	Relationship	Phone

Please list any conditions of disclosure: _____

I give authorization for Carolina Oncology Specialists, PA to communicate with me regarding my Private Health Information in the following manner (please check the item(s) that apply):

- Leave message on my home voicemail/cell phone Yes No
- Send Message via Text Message Yes No
- Email (non-encrypted) Yes No

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____ **Date:** _____

Living Will & Power of Attorney

Do you have a living will? Yes No **If yes, please provide a copy for our file.**

Medical Power of Attorney to make medical decisions on your behalf? Yes No

If yes, please provide a copy for our file. Also, please provide their information below:



Patient Name: _____
Date of Birth: _____

FINANCIAL RESPONSIBILITY FORM

Agreement

Financial Responsibility

Please read each line below and sign the page to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

For patients with no insurance coverage, payment is due at the time of service. As a self-paying patient you will receive a discounted rate on your visits as long as payment is made in full on the date of service. If other arrangements are agreed upon, full charges are applicable. We accept cash, checks, and all other major credit cards.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

It is the patient's responsibility to notify us of any changes in insurance, mailing address, or contact information.

Your signature below signifies that you have read each item and understand your responsibility to this office as well as our responsibility to you and your care.

Patient Signature _____ **Date:** _____

Patient Name _____ DOB ____/____/____ (mm/dd/yyyy)
 Date of Appointment ____/____/____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment

PAST MEDICAL HISTORY (please check any medical problems that you have had in the past)

CANCER HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Bladder cancer | <input type="checkbox"/> Esophageal cancer | <input type="checkbox"/> Pancreatic cancer |
| <input type="checkbox"/> Bone cancer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Brain cancer | <input type="checkbox"/> Lung cancer | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Small intestine cancer |
| <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Stomach cancer |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Uterine cancer |
| <input type="checkbox"/> Other (list) _____ | | |

MEDICAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> COPD (lung disease) | <input type="checkbox"/> Myocardial infarction (heart attack) |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Nerve/muscle disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Polycythemia vera |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibrocystic breast | <input type="checkbox"/> Polymyalgia rheumatic |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD (heartburn) | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Breast problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Lupus | <input type="checkbox"/> TIA (transient ischemic attack) |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congestive heart failure | | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Other (specify) _____ | | |

SURGICAL HISTORY

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Arterial bypass | <input type="checkbox"/> Cholecystectomy (gall bladder) | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Other (list) _____ | |

Do you have a Living Will? Yes No
 Do you have a Healthcare Power of Attorney (POA)? Yes No
 If Yes, Name of POA _____

Patient Name _____ DOB ____/____/_____(mm/dd/yyyy)

ALLERGIES

Are you allergic to any medications? Yes No If YES, please list med and reaction:

MEDICATIONS: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins

	Medication	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

FAMILY HISTORY

Check below to report problems your family members have had. Please state the age when they had the problem if you know.

I was adopted and my family medical history has not been disclosed to me

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia problems							
Bleeding disorder							
Blood count disorder							
Cancer- breast							
Cancer- colon							
Cancer- leukemia							
Cancer- lung							
Cancer- lymphoma							
Cancer- melanoma (skin)							
Cancer- multiple myeloma							
Cancer- ovarian							
Cancer- sarcoma							
Cancer- other (specify)							
Clotting disorder							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Stroke							
Other (specify)							
Alive and Age (Yes, No, n/a)							

Patient Name _____ DOB ____/____/____(mm/dd/yyyy)

IMMUNIZATIONS: Please indicate any immunizations you were given by listing the estimated month and year it was administered.

Covid ____/____ Influenza ____/____ Pneumonia ____/____
RSV ____/____ Shingles ____/____ HPV (genital warts) ____/____

REVIEW OF SYSTEMS (please circle any **current** problems you have on the list below)

General

Fatigue / Weakness
Restless Sleep
Daytime Drowsiness
Unhappiness
Depression / Sadness
Feeling "Blue" or "Hopeless"
 for more than 2 weeks
Lack of Motivation
Excessive Irritability
Feelings of Worthlessness
Nervous / Anxiety
Unexplained Fever >100°
Frequent Night Sweats
Unexplained Weight Loss
Unexplained Weight Gain
Excessive Thirst

Skin

Changes in Moles
Rash / Skin Spots / Growth
Bruise Easily
Itching
Excessive Hair Growth
Hair Loss

Ears/Nose/Throat

Allergy Symptoms
Hearing Loss
Ringing in Ears
Dizziness / Dizzy Spells
Nose Bleeds
Sinus Problems
Hoarseness

Explanation: _____

Eyes

Eye Pain
Double Vision
Change in Vision
Itchy / Watery Eyes

Lungs

Cough / Wheeze
Snoring/ Gasping
Difficulty Breathing
Positive TB Skin Test

Heart

Chest Pain / Pressure
Exercise Intolerance
Heart Murmur
Palpitations
Irregular Pulse
Fainting Spells
Swollen Ankles

Leg Pain with Walking

Gastrointestinal

Heartburn / GERD
Change in Bowel Habits
Difficulty Swallowing
Abdominal Pain
Nausea / Vomiting
Diarrhea / Constipation
Bloody / Black Stools
Frequent Laxative Use

Musculoskeletal

Muscle / Joint Pain
Joint Swelling
Chronic Back Pain
Gout

Genitourinary

Frequent Urine Infections
Painful Urination
Frequent Urination
Urinary Leakage / Incontinence
Blood in Urine
Overnight Urination > 2 trips
Sexual Function Problems

Male

Decrease in Force Urination
Erection Problems
Testicle Lumps / Swelling

Female

Vaginal Discharge / Itching
History of Abnormal Pap Smear
Pain / Bleeding During Intercourse
Significant Menstrual Cramps
Hot Flashes / Night Sweats

Menstrual History

Age of onset _____ or Menopause
Reg or Irreg cycle
Flow: light / moderate / heavy
Length of cycle: Days of flow _____
of pregnancies ____/ births ____
of miscarriages / abortions _____

Breast

Pain / Lumps / Discharge

Neurological

Frequent Headaches
Numbness / Tingling
Memory Loss
Tremor / Shaking

Patient Name _____ DOB ____/____/____(mm/dd/yyyy)

ROUTINE CANCER SCREENING TESTS (list date of last test)

TEST	DATE OF LAST	TEST	DATE OF LAST
Mammogram		Prostate Exam	
Breast Exam		Prostate PSA	
Pap Smear/Pelvic Exam		Chest X-Ray	
Stool for Occult Blood		Colonoscopy	

SOCIAL HISTORY

Tobacco Use

(please check one)

- I have never smoked
- I have smoked, but rarely
When was the last time? _____
- I have quit smoking. Quit Date _____
How many packs/day? _____ # years _____
- I currently smoke _____ packs/day
years? _____

Other Tobacco:

- pipe cigar snuff chew vape
- Are you interested in quitting? Yes No

Sexual History

Are you sexually active? Yes No
Current sexual partners(s): male female
Birth control method _____

Exercise

Do you exercise regularly? Yes No
How often? Daily 4-6 times/week 1-3 times/week less than one time a week

What form of exercise? (ie: walking, jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? Yes No
Is violence at home a concern for you? Yes No
Are you currently in a relationship? Yes No
If yes, do you feel safe in this relationship? Yes No
Any other concerns? _____

Social Demographics

Marital Status: single engaged living w/partner
 married separated divorced widowed

Occupation _____

Education completed grade school high school college graduate school

Number of children _____ Who lives with you? _____

Frequent foreign travel? Yes No Where? _____



A Partner of OneOncology

AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: ____/____/____

PHONE: _____

PURPOSES OF DISCLOSURE:

- Legal Personal Use Physician Request
- Changing Physicians Insurance Other _____

SPECIFIC INFORMATION TO BE RELEASED (Example: Office Visit Notes, Laboratory Reports, etc.)

FROM:

TO:

Carolina Oncology Specialists, PA
2711 Randolph Road, Suite 400
Charlotte, NC 28207

General Phone: 704-342-1900
Fax: 704-377-0353

Note: As to what may be released, it will be at the medical office's discretion. The amount reasonably necessary for certain identified purposes, pending purpose of disclosure.

DATES OF SERVICE RANGE: FROM ____/____/____ TO ____/____/____

Note: By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include final findings, diagnosis, treatment, assessment, dates of service, psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you. I understand that this authorization will expire 90 days from the date of signature.

Signature of Patient	Date	
Parent/ Legal Guardian/ Authorized Person	Date	Relationship to patient

NOTICE TO PATIENTS: The patients or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed.

Return completed and signed form by fax 704-377-0353; or mailing to the address listed; or in person during office business hours.



AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____ / _____ / _____

ADDRESS: _____

CITY, STATE, ZIP: _____ PHONE: _____

CAROLINA ONCOLOGY SPECIALISTS, PA MAY RELEASE THE FOLLOWING INFORMATION:

- | | | |
|--|--|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Financial Records | <input type="checkbox"/> Office Visit Notes |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Diagnosis/Studies | <input type="checkbox"/> Office Visit Notes |

ENTITY OR PERSON WHO WILL RECEIVE THE INFORMATION:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ PHONE: _____

Send the information electronically. Email address: _____

Send the information via Fax. Fax# _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed in the document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____

Print Name of signature above: _____

DATE: _____

*Description of Personal Representative's Authority (attach necessary documentation)

Revoked by patient or personal representative on

HOW REVOKED: Orally (if person or via phone) In writing (place copy in patient's file)