FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____
DOB: _____
MRN: _____

FOR OFFICE USE ONLY

Name: _____

Today's date: _____ Date of birth: _____

SSN: _____ Preferred language: _____

Primary address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Cell phone: (_____) _____

May we leave voicemail messages?: ☐ Yes ☐ No

Email address: _____ May we email you? ☐ Yes ☐ No

Reason for your appointment: _____

Referred by: _____ ☐ **N/A**

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other: _____

Primary Care Physician: _____ **Phone: (____)** _____

Referring Physician (if different): _____ Phone: (_____) _____

Please list any additional Physicians you see (include phone number):

_____ Phone: (_____) _____

_____ Phone: (_____) _____

_____ Phone: (_____) _____

_____ Phone: (_____) _____

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Pharmacy name: _____

Pharmacy phone number and cross streets: _____

Emergency contact name: _____

Relationship: _____ Phone: (_____) _____

Is there a person who you would like as your primary/emergency contact regarding your healthcare?

☐ Yes ☐ No If yes, name: _____

Relationship: _____ Phone: (_____) _____

Do you have: *An advance directive*?* ☐ Yes ☐ No *A living will?* ☐ Yes ☐ No
A DNR? ☐ Yes ☐ No *A healthcare proxy?* ☐ Yes ☐ No

**If yes, please provide.*

Personal Medical History

Have you ever been told by a doctor/health care professional that you had cancer? ☐ **Yes** ☐ **No**

Type of cancer diagnosed: _____ Year: _____

Treating physician: _____

Previous treatment for cancer and date (if applicable):

☐ Radiation _____ ☐ Chemotherapy _____ ☐ Immunotherapy _____

☐ Surgery _____ ☐ Hormone therapy _____ ☐ Targeted therapy _____

☐ Other: _____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No **If yes**, did you have a reaction? ☐ Yes ☐ No

Date of last blood transfusion: _____

Do you have religious restrictions that prevent you from accepting blood transfusions? ☐ Yes ☐ No

Previous medications: _____

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Check the items that apply to you (current or history):

- ☐ None
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Chronic back pain
- ☐ Chronic Lung (COPD)
- ☐ Cirrhosis of Liver
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Use
- ☐ Enlarged prostate
- ☐ Fracture
- ☐ Freq. Urinary Tract Infections
- ☐ Frequent Infections
- ☐ Gallstones
- ☐ GERD/Heartburn
- ☐ Glaucoma/Cataracts
- ☐ Hearing Loss
- ☐ Heart Murmur
- ☐ Heart Attack-MI
- ☐ Heart Disease
- ☐ Heartburn/Reflux
- ☐ Hepatitis A/ B/ C
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease/Failure
- ☐ Kidney Stone
- ☐ Leukemia
- ☐ Lupus-Autoimmune
- ☐ Lymphoma
- ☐ Major Depression
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia/Bronchitis
- ☐ Problems with Anesthesia
- ☐ Reynaud's Syndrome
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ TB (Tuberculosis)
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis

Gynecologic history:

Age menstruation began: _____ Last menstrual period: _____

Cycle length & frequency: _____ History of abnormal bleeding: ☐ Yes ☐ No

Age of patient during first pregnancy (if applicable): _____ Did you breast feed? ☐ Yes ☐ No

Age of menopause (if applicable): _____ Last Pap test: _____

Have you had hormone replacement therapy? ☐ Yes ☐ No Have you taken birth control? ☐ Yes ☐ No

Gynecologist: _____ Phone: (_____) _____

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Symptoms:

General
- ☐ Change in appetite
- ☐ Change in weight
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Frequent colds

Eyes
- ☐ Glasses/contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision

Ears, nose, mouth, throat
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Sinus trouble
- ☐ Post nasal drip
- ☐ Dental problems
- ☐ Sore mouth, tongue or lips
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums

Heart
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Murmur
- ☐ Swollen feet or ankles

Lungs
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum or phlegm production
- ☐ Difficulty breathing when flat

Musculoskeletal
- ☐ Joint Pain/Arthritis
- ☐ Muscle or Joint Weakness
- ☐ Back Pain
- ☐ Bone Pain
- ☐ Muscle Aches

Genitourinary
- ☐ Excessive nighttime urination
- ☐ Excessive daytime urination
- ☐ Slow starting or stopping
- ☐ Urine leakage
- ☐ Pain/burning with urination
- ☐ Pelvic pain
- ☐ Blood in the urine

Men only
- ☐ Prostate infections
- ☐ Impotence

Women only
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Painful intercourse
- ☐ Cramping

Digestive
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Belching or excess gas
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Hemorrhoids

Endocrine
- ☐ Hot flashes

Immunologic
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever

Skin
- ☐ Rash, hives or itching
- ☐ Change in color
- ☐ Change in mole or wart
- ☐ A sore that won't heal

Nervous system
- ☐ Headaches
- ☐ Dizziness or vertigo
- ☐ Fainting
- ☐ Convulsions, seizures or tremors
- ☐ Memory loss
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Numbness in arms or legs

Blood disorders
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ Blood transfusion(s)

Psychiatric
- ☐ Anxiety Disorder
- ☐ Major Depression
- ☐ Trouble sleeping/insomnia
- ☐ Work/family stress

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Health Maintenance:

Sigmoidoscopy / Colonoscopy: ☐ Yes ☐ No Date: _____

Findings: _____

_____

Last Mammogram date: _____ **Last Bone Density date:** _____ **Last Pelvic Exam date:** _____

Last EGD date: _____ **Last Colonoscopy date:** _____ **Last Prostate Exam date:** _____

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

Date	Hospitalization	Where	Doctor

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Family History

Indicate any family members with cancer, blood disease or other disease:

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____

	Age	Gender	Disease	If deceased, cause of death
Siblings:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

	Age	Gender	Disease	Paternal/ Maternal	If deceased, cause of death
Grandparents:	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

☐ Adopted - family history not known ☐ Ashkenazi Jewish ancestry

Do you have a family history of blood clots or bleeding disorders? ☐ Yes ☐ No

If yes, please describe: _____

_____

Social History

Current marital or relationship status: ☐ Married ☐ Single ☐ Divorced or separated ☐ Widowed ☐ Domestic partnership or civil union ☐ Prefer not to answer

Name of spouse/partner: _____

Children?: ☐ Yes ☐ No If Yes, how many?: _____

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Occupation: _____ ☐ Retired
(previous if retired)

What is your current gender: ☐ Male ☐ Female ☐ Gender identity: _____ *(Optional)*
☐ Decline to answer

What sex were you assigned at birth?: ☐ Male ☐ Female

Do you currently use tobacco products? ☐ Yes ☐ No **If yes, use per day (please enter number):**

Cigarettes: _____ Cigars: _____ Pipe: _____ Chewing tobacco: _____ Electronic cigarettes: _____

For how many years have you used the above tobacco product(s)? _____

If no, have you ever used tobacco products ***in the past?*** ☐ Yes ☐ No

When did you quit? _____ For how many years did you use the above tobacco product(s)? _____

How many servings of alcoholic beverages (wine, beer, liquor) do you drink per day? _____

Per week? _____ Do you have a history of heavy alcohol use? ☐ Yes ☐ No

Allergies

Are you allergic to any medications? **If yes,** please list mediation and reaction to the medication:

_____

_____

Are you allergic to:

Latex: ☐ Yes ☐ No **Tape:** ☐ Yes ☐ No **If yes,** please list the type of tape: _____

Eggs: ☐ Yes ☐ No **Vaccines:** ☐ Yes ☐ No **If yes,** please list the type of vaccine(s): _____

CT Contrast/Dye: ☐ Yes ☐ No

Please list any other allergies: _____

_____

_____

_____

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Medications: *List current prescriptions and over-the-counter medications, including herbals, supplements and vitamins.*

Medication	Dosage	Frequency

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Immunizations: *Please mark previous immunizations received and include* ***date of last vaccine****.*
This page is optional if dates are unknown.

Immunization	Date(s)
☐ Varicella	
☐ Pneumococcal	
☐ Tetanus Diptheria and Pertussis	
☐ COVID (list dates of vaccines and boosters)	
☐ Hepatitis B	
☐ Shingles	
☐ Flu	
☐ Hemophilus (HIB)	

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AUTHORIZATION & RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORD (EMR)

I authorize Florida Cancer Specialists & Research Institute (FCS) to take my photograph (digital camera/ video may be used). These photos may then be placed in my FCS electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have reviewed this authorization form.

☐ I consent

☐ I do not consent

_____ _____

Patient Name (Print) Date

_____

Patient or Guarantor (Signature)

FLORIDA CANCER SPECIALISTS & Research Institute

REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

_____

_____

Name and Address of Practitioner

To be sent to Florida Cancer Specialists & Research Institute: *(Internal use)*

_____

Address, City, State, Zip Code

_____

Fax/Telephone Number

☐ I give permission to fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via phone line.

It is my understanding that by signing this authorization for release of my records, I am giving permission for FCS to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization.
I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

_____ _____

Patient Name (Print) Date

_____ _____

Patient or Guarantor (Signature) Date of birth

FLORIDA CANCER SPECIALISTS & Research Institute

CONSENT TO DISCLOSE VERBAL MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

Please check one of the following:

☐ I give my permission to the employees of Florida Cancer Specialists & Research Institute to disclose my Protected Health Information verbally to me and the following family members or friends:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

☐ I request that all my Protected Health Information be disclosed ONLY to me and no other family members or friends.

☐ I give permission to Florida Cancer Specialists & Research Institute to use a professional medical scribe, who may be virtual, to assist my physician in documentation while I discuss my healthcare issues. I understand that I do not have to pay for this service and that all information shared will be kept confidential.

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

_____ _____
Patient (Signature) Date

_____ _____
Patient (Print Name) Date

This form must be updated annually.

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INSURANCE INFORMATION

Patient Name: _____ **DOB:** _____

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policynumber/Group ID: _____

Policy holder's date of birth: _____

Policy holder's employer: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____

Policynumber/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SSN: _____

Policy holder's employer: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder: _____

RX policy number/RX BIN number: _____

I certify that the information provided is accurate. I will notify Florida Cancer Specialists & Research Institute (FCS) of any changes as soon as they become available. I understand that it is my responsibility to update FCS of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

_____ _____
Patient Name (Print) Date

_____ _____
Patient or Guarantor (Signature) Date of birth

FLORIDA CANCER SPECIALISTS & Research Institute

FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

Thank you for choosing Florida Cancer Specialists & Research Institute (FCS) as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge FCS' patient financial policies:

- You agree to provide FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify FCS if your coverage changes.
- You understand that FCS patient financial policies are available online at FLCancer.com You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that FCS will bill your insurance plan or program for services provided by FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to FCS and you are authorizing payment to be made directly to FCS.
- You agree you are responsible for payment to FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- FCS owns and operates Rx To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use Rx To Go and may have your prescriptions filled wherever you choose. However, if you select Rx To Go to fill FCS-issued prescriptions, then this policy and all other FCS patient financial responsibility policies will also apply to the items and services provided to you by Rx To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by FCS clinicians at FCS' own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.

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- If you make a payment to FCS that results in a surplus on your account (i.e., a credit balance), FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of FCS' care a credit balance remains which is not subject to return to your insurer or other payer, FCS will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

☐ **I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.**
A copy is available to the patient upon request

Patient Name (Print) _____ Date of birth _____

Patient or Guarantor (Signature) _____ Date of birth _____

For office use:

Name (Print) _____

FCS Employee (Signature) _____

FLORIDA CANCER SPECIALISTS & Research Institute

MEDIGAP

Only applicable for patients with secondary insurance to Medicare

Name of Beneficiary: _____

Health Insurance Claim Number: _____

Medicare Beneficiary Identifier: _____

Medigap Policy Number: _____

I request that payment of authorized Medigap benefits be made on my behalf to Florida Cancer Specialists & Research Institute or Rx To Go for any services furnished by _____.
I authorize any holder of medical information about me to release to _____ any information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

_____ _____
Patient Name (Print) Date

_____ _____
Patient or Guarantor (Signature) Date of birth

FLORIDA CANCER SPECIALISTS & Research Institute

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of Florida Cancer Specialists & Research Institute Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Florida Cancer Specialists & Research Institute facility or by submitting a request in writing to the corporate office at Florida Cancer Specialists & Research Institute, 4371 Veronica S. Shoemaker Blvd., Fort Myers, FL 33916.

You may also obtain a copy of the Notice of Privacy Practices by visiting Florida Cancer Specialists & Research website at FLCancer.com, select the **Patient Guide** tab, select **New Patient Forms** and click on **Notice of Privacy Policies**.

Date:_____

☐ Accepted ☐ Declined

_____

Patient Name (Print)

_____ _____

Patient or Guarantor (Signature) Date of birth

Relationship to Patient: _____

FLORIDA CANCER SPECIALISTS & Research Institute

CONSENT TO SMS COMMUNICATION

By signing below, I authorize Florida Cancer Specialists & Research Institute, LLC (FCS), its affiliate and subsidiary entities, and Rx To Go, LLC (and any authorized FCS texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by FCS under my cell phone plan.

I know that I am under no obligation to authorize FCS to send me text messages. I may opt-out of receiving these communications at any time by responding with "STOP."

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

Risk of using text messages: The use of text messages has a number of risks that should be considered. These risks include, but are not limited to the following:

- Text messages can be circulated, forwarded, stored electronically and on paper to unintended recipients.
- Senders can easily misaddress a text message and send the information to an undesired recipient.
- Backup copies of text messages may exist even after the sender and/or the recipient has deleted his/her copy.
- Text messaging may not be secure, and is therefore it is possible that a third-party may breach the confidentiality of such information.

PLEASE MARK THE FOLLOWING:

☐ I consent to receiving information via text. I understand I can withdraw my consent at any time. Text cell number _____

☐ I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

I, _____ [Patient Name], hereby consent and state my preference to have my physician, _____ [Physician Name], and other staff at Florida Cancer Specialists & Research Institute, LLC (FCS), its affiliate and subsidiary entities, and Rx To Go, LLC (and any authorized FCS texting service vendor) communicate with me by standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that standard SMS messaging is not a confidential method of communication and may be unsecure. I further understand that, because of this, there is a risk that standard SMS messaging regarding my medical care might be intercepted and read by a third party.

_____ _____

Patient Name (Print) Date

_____

Patient (Signature)