SOUTHERN ONCOLOGY SPECIALISTS

Date:_____

## Patient Information

Name:_____
(LAST) (FIRST) (MIDDLE INITIAL)

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Social Security No:_____ Sex: ☐Male ☐Female ☐Other

Home Ph:_____ Cell Ph:_____ Email:_____

Employed? ☐YES ☐NO Employer:_____ Work Ph:_____

**Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino | **Race:** ☐Asian ☐Black or African-American ☐White

☐American Indian ☐Native Hawaiian or Other Pacific Islander ☐Other_____ ☐Decline

Emergency Contact Name:_____

Relation:_____ Emergency Contact Phone:_____

**Do you have any of the following advanced directives? Living Will: ☐YES ☐NO Power of Attorney: ☐YES ☐NO**

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## Physician and Pharmacy Information

Referring Doctor:_____ Phone:_____

Primary Physician:_____ Phone:_____

Pharmacy:_____ Phone:_____

Address:_____

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## Insurance Information

PRIMARY Insurance:_____ Phone:_____

Policy Holder's Name:_____ Relationship:_____

Policy Holder's Date of Birth:_____ Policy Holder's SSN/ ID #:_____

Group No:_____ Employer:_____ Cobra Plan ☐ Worker's Comp ☐

SECONDARY Insurance:_____ Phone:_____

Policy Holder's Name:_____ Relationship:_____

Policy Holder's Date of Birth:_____ Policy Holder's SSN/ ID #:_____

Group No:_____ Employer:_____ Cobra Plan ☐ Worker's Comp ☐

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## Patient Medical History

Patient Name:_____Date of Birth:_____

**Current Medications:** Please list all current medications; prescription and non-prescription. (This includes any over-the-counter supplements, vitamins, eye drops, patches, topical-use products, laxatives, stool softeners, nasal sprays, or inhalers. Other examples: Tylenol, baby aspirin, CBD oil, other essential oils, Cold+Flu products)

| Medication | Dose | How do you take/use it? |
|---|---|---|
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| | | |
| | | |
| | | |
| | | |
| | | |

Allergies to medications or any adverse reactions to medications:_____

_____

## Social History

Current occupation:_____How long have you worked there?_____

Prior occupations:_____

Any exposure to toxins? ☐ YES ☐ NO If yes, where? _____

Any exposure to asbestos? ☐ YES ☐ NO If yes, where?_____

Do you exercise? ☐ YES ☐ NO If yes, what type and how often?_____

Tobacco Use: ☐ Never Smoked
☐ Quit Smoking, when?_____How many years did you smoke?_____How many packs per day?_____
☐ Currently smoke ☐ Cigarettes How many packs per day?_____ ☐ Pipe ☐ Cigars How many years?_____
☐ Chewing Tobacco How many years?_____
Alcohol Use: ☐ YES ☐ NO If yes, how many drinks per week?_____Illegal drug use: ☐ YES ☐ NO If yes, please specify:_____

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**Reproductive History for Women**

Age when you began having periods:_____How old were you when you first gave birth?_____

How many children have you had?_____Have you had any miscarriages? ☐ YES ☐ NO If yes, how many?_____

Last Pap Smear:_____Have you gone through menopause? ☐ YES ☐ NO If yes, what age?_____

Have you had a hysterectomy? ☐ YES ☐ NO If yes, what age?_____Were your ovaries removed? ☐ YES ☐ NO
Have you ever taken hormone replacement therapy? ☐ YES ☐ NO If yes, what did you take and for how long?

_____

Have you ever used a form of birth control? ☐ YES ☐ NO If yes, what form and how long?

_____

**Past Medical History:** Please check all boxes that apply, specify if needed:

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV | ☐ Diabetes | ☐ MRSA | ☐ Tuberculosis |
| ☐ Allergies | ☐ Dizziness/Fainting Spells | ☐ Numbness/Tingling | ☐ Tumor/Growth |
| ☐ Anemia/Blood Disorder | ☐ GERD/Acid Reflux | ☐ Osteoporosis | ☐ Ulcers |
| ☐ Arthritis/Gout | ☐ Glaucoma | ☐ Pancreatitis | ☐ Vision Loss |
| ☐ Asthma/Lung Issues | ☐ Hearing Loss | ☐ Radiation | |
| ☐ Blood clots | ☐ Heart Attack | ☐ Seizures/Convulsions | |
| ☐ Bone or Joint Injury | ☐ Heart Disease | ☐ Shingles | |
| ☐ Cancer | ☐ Hepatitis/Liver Disease | ☐ Sickle Cell Disease | |
| ☐ Cataracts | ☐ High Cholesterol | ☐ Sinusitis | |
| ☐ Chemotherapy | ☐ High Blood Pressure | ☐ Stomach/Intestinal Issue | |
| ☐ Colon Issue/Colitis | ☐ Irregular Heartbeat | ☐ Stroke | |
| ☐ COPD/Emphysema | ☐ Kidney Disease/Dialysis | ☐ Thyroid Issue | |

Other:_____

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## Surgical History

☐ Appendectomy ☐ Biopsy ☐ Arterial Bypass ☐ Cholecystectomy ☐ Splenectomy
☐ Back Surgery ☐ Other:_____

**Routine Screening Tests and Vaccines:** Please check each that you have had and the month and year when (if known)

| | |
|---|---|
| Mammogram: | Breast Exam: |
| Bone Density: | Colonoscopy: |
| Scans (CT, MRI, X-Ray, PET): | |
| Flu shot: ☐ YES ☐ NO If yes, Date:_____ | Pneumonia Vaccine: ☐ YES ☐ NO If yes, Date:_____ |
| Hep B: ☐ YES ☐ NO If yes, Date:_____ | Shingles Vaccine: ☐ YES ☐ NO If yes, Date:_____ |

## Family History

| | Mother | Father | Sister | Brother | Daughter | Son | Other (list) |
|---|---|---|---|---|---|---|---|
| Anesthesia problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Bleeding disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Blood count disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cancer-Specify type below and put age they were diagnosed in box | | | | | | | |
| Cancer- | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cancer- | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cancer- | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cancer- | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cancer- | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Clotting disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Heart Attack | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Alive and Age | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

In your opinion, are there any diseases that run in your family? ☐ YES ☐ NO

Please list:_____

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**HIPAA**
**Authorization for Release of Information-Compound Release**

Patient Name:_____Date of Birth:_____

Phone Number:_____

May we leave appointment/labs/x-ray information and/or results on your voicemail? ☐ YES ☐ NO

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**Southern Oncology Specialists, PLLC. is authorized to release protected information about the above named patient to the entities named below according to the patient's instructions.**

| Name/Relation to Patient | Phone Number | Check all that apply: |
|---|---|---|
| | | ☐ Financial ☐ Medical ☐ Appointments |
| | | ☐ Financial ☐ Medical ☐ Appointments |
| | | ☐ Financial ☐ Medical ☐ Appointments |

For E-mail Communication Please provide email address* _____
*In order for email communication to occur, please accept the disclosure below:
☐ For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, I still elect to move forward to allow email communications to occur.

Please check each that can be released via email: ☐ Financial ☐ Medical ☐ Appointments ☐ Breach Notification

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**Patient Rights**

- I have the right to revoke this authorization at any time, by contacting Southern Oncology Specialists.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective in 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.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Patient Signature:_____Date:_____

SOUTHERN ONCOLOGY SPECIALISTS

**Financial Policies Agreement**

Dear Southern Oncology Specialists Patient,

Thank you for choosing Southern Oncology Specialists as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

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

- You agree to provide SOS with current and accurate insurance, health care benefits program and/or payer information, and to immediately notify SOS if your coverage changes.
- You acknowledge that SOS will bill your insurance plan or program for services provided by SOS, and you agree you are assigning your right to receive payment or benefits from such insurer or program to SOS and are authorizing payment to be made directly to SOS.
- You agree that you are responsible for payment to SOS of all co-pays, deductibles, and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amount 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 laws and regulations 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, SOS will use your personal health information internally and will share such information with your health care payer/plan and certain business associates of SOS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law regulation.
- SOS owns and operates SOS Pharmacy, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your SOS 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 SOS Pharmacy and may have your prescriptions filled wherever you choose. However, if you select SOS Pharmacy to fill SOS-issued prescriptions, then this policy and all other SOS patient financial responsibility policies will also apply to the items and services provided to you by SOS Pharmacy.
- You acknowledge that laboratory services may be necessary as part of your care and treatment which may be performed by SOS clinicians at SOS's own laboratory facilities. In some cases, laboratory services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside laboratory provider.

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES. A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST.**

_____ _____

Printed Name of Patient Date

_____

Signature of Patient (or Patient's Legal Representative)

_____

Printed Name of Legal Representative and Relationship to Patient

SOUTHERN ONCOLOGY SPECIALISTS

**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 Southern Oncology Specialists Notice of Privacy Practice.

This notice is available in hard copy or verbally requesting a copy at the front desk of any Southern Oncology Specialists facility or by submitting a request in writing to the Huntersville location at:

Southern Oncology Specialists
9930 Kincey Ave Ste 165
Huntersville, NC 28078

_____ _____
Patient Signature Date

_____ ____/____/____
Print Name Date of Birth

_____ _____
Guardian/Representative Signature Date

_____
Relationship to Patient