



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

Physician and Pharmacy Information

Referring Doctor: _____ Phone: _____

Primary Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Address: _____

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

HUNTERSVILLE:

9930 Kinsey Ave,
Suite 165
Huntersville, NC 28078

DENVER:

268 Gillman Rd,
Suite A
Denver, NC 28037

MOORESVILLE:

146 Medical Park Rd,
Suite 212
 Mooresville, NC 28117

CHARLOTTE:

10320 Mallard Creek Dr,
Suite 100
Charlotte, NC 28262

STATESVILLE:

1405 Fern Creek Dr
Statesville, NC 28625

HICKORY:

2660 Tate Blvd SE,
Suite 201
Hickory, NC 28602



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?

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: _____



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:

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

Other: _____



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: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Date: _____ Pneumonia Vaccine: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Date: _____	
Hep B: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Date: _____ Shingles Vaccine: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Date: _____	

Family History

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

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

Please list: _____



**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

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:
		<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointments
		<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointments
		<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> 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

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: _____



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



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 Kinsey Ave Ste 165
Huntersville, NC 28078

Patient Signature

Date

Print Name

_____/_____/_____
Date of Birth

Guardian/Representative Signature

Date

Relationship to Patient