

Patient Information

Last Name:		First Name:		MI:	Salutation:		
Date of Birth:	Date of Birth: SSN:			Referrin	g Physician:		
Is this your legal name? OY ON	If not, wha	at is your legal	name?	Former N	ame:		
Marital Status:	al Status: Sex: Gender: <u>I</u>			ouns: (please circle) ne/Her He/Him They/Them			
Street Address:		Cit	y:	State:	Zip:		
PO Box: (if applicable	le) Email /	Address:					
Home Phone:		Cell Phone:		Work Pho	one: (or other number)		
Employment Stat		·	loyer:	Occup	pation:		
Preferred Contact Method: (please circle) Home Phone Cell Phone Work Phone Email Text Preferred Language:					eferred Language:		
In Case of Emergency							
Emergency Contact Name: Relationship to Patient:							
Phone Number:			Other Phone Number: (please specify)				
If the Patient is <u>not</u> the Policyholder:							
Policyholder Name: DOB:				SSN:			
Policyholder Signature:							
Advanced Care Planning							
Is the patient in possession of the following documents? (please circle)							
Living Will Power of Attorney Healthcare Proxy Advance Directive N/A							



Physician & Pharmacy Information

Primary Care Provider (PCP):	PCP Phone Number:
Preferred Pharmacy:	Pharmacy Phone Number:
Pharmacy Street Address:	City: State: Zip:
Please list ALL active treating physicia (e.g. Cardiologist, Internist, Pulmonolog	
Doctor's Name	Specialty
Demographic Data	
Collection of the following information is en	acouraged by federal health agencies.
_	ove the quality of care provided to all patients.
Race: Asian	American-Indian or Alaska Native
☐ Black or African-American	☐ Native Hawaiian or Pacific Islander
White	Decline Response Other:
Ethnicity: Hispanic or Latino	Not Hispanic or Latino Other:
How did you find us?	
Family/Friend Radio	Television Referring Physician
Online Search Billboard	Drive-by Other:
Social Media Print Ad	Community Event
	_ ′



Patient Name:					DOB:							
Reason For	Visit	:										
Are you experi	encing	g pair	n today	? If	so, r	olease	indi	cate	belov	V:		
no pain											unbea	arable pain
000	1 () 2	Оз	C) 4	O 5	TC	6	07	7 08	09	0 10
Cancer Histo	ry (p	lease	mark all	that	t appl	y)		1			1	
								G	randp	parents		
Туре	N/A	Self	Mother	r Fa	ather	Siblin	g(s)	Mat	ternal	Paternal	Other	Comments
Lung												
Breast												
Prostate												
Colorectal												
Head & Neck												
Skin												
Gynecological	i											
Other:												
			 									
Are you of Asl	hkenaz	zi Jew	ı vish Des	cen	t? O	Y ON						
-					-							-
Surgical Hist	ory/N	/lajor	Hospi	tali:	zatic	ons						
Procedure			(MM/YY				Hosp	oital		Reasor	n/Comp	olications
			<u>· · · · · · · · · · · · · · · · · · · </u>								· .	
Social Histor	`\/											
300 101.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	y		Yes N	Vo.	Quit	Com	mer	nts				
Do you drink a	alcohol	 ?	1.50	+					ek:			
Do you smoke									d:	Packs	s per da	٠
Do you use ille						1001	<i>3</i> 311.	Once	1) pc. 43	19
or controlled s	substar	nces?										
Weekly exercis	se rout	ine?										
Describe your	typica	I diet:										



Medication List					
Name	Dosage	# of times per day	Route (oral/injection?)		

Exams & Vaccines	Please list the dates and	I results of any of the following that you may have had
Туре	Approximate Date	Results (if applicable)
Physical Exam		
Colonoscopy		
Mammogram		
Pap Smear		
Flu Vaccine		
HPV Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Covid-19 Vaccine		
Other:		

Allergies		
Category	Type of Allergen	Reaction to Allergen
Food		
Medication		
Latex		
Contrast/IV Dye		
Other:		



Patient Name:	DOB:
Review of Systems	
Medical History	Current Symptoms
Please circle all that apply General	Please circle all that apply
	Fever Fatigue Night Sweats Chills Weakness Weight Change Other:
Neurological	
☐ Migranes ☐ Seizures	Headaches Poor Coordination Numbness/Tingling Dizzines Changes: Memory Motor Function Other:
ENT Tinnitus (Ringing in the ears)	Ear Pain Hearing Loss Nose Bleeds Hearing Aid Dry Mouth Hoarseness Changes in Taste Dentures Sore Throat Difficulty Swallowing Other:
Eyes Cataracts Glaucoma Macular Degeneration	Vision: Blurry Changes Contacts or Glasses Double Light Intolerance Other:
Endocrine Diabetes Thyroid Disorder	Excessive Thirst Cold or Heat Intolerance Other:
Cardiovascular Congestive Heart Failure Heart Disease Hypertension Murmurs Palpitations	Chest Pain Elevated Cholesterol Pacemaker Fainting Recent Change in Exercise Tolerance Leg Swelling
Stroke	Other:
Hematologic/Lymphatic Anemia Bleeding Disorder Blood Transfusion	Abnormal Bleeding Abnormal Bruising Other:
Respiratory	
Asthma Bronchitis Emphysema Pneumonia	Wheezing Chest Congestion Oxygen Use Shortness of Breath Cough: Productive Nonproductive Other:
Tuberculosis	Systems Review Page 1 of 2



Medical History	Current Symptoms
Please circle all that apply	Please circle all that apply
Gastrointestinal Constipation Gallbladder Disease GERD (Heartburn) Liver Disease	Diarrhea Ulcers Bowel Incontinence Vomiting Nausea Blood in Stool (Black or Tarry) Decreased Appetite Pain: Abdominal Rectal Other:
Genitourinary Urinary/Kidney Disorder	Sexual Function Concerns Pelvic Pain Urination: Blood Frequency Hesitancy Pain Weak Stream Incontinence Urgency Infections Frequent Urination at Night Other:
Womens' Health: Abnormal Pap Smear Past Pregnancies (#) Past Deliveries (#)	Hot Flashes / Night Sweats Pain/Bleeding During Sex Currently Pregnant Vaginal Discharge/Itching Significant Pain/Cramps with Menses Breast: Discharge Lumps Pain Nipple Inversion Other:
Mens' Health:	Erectile Concerns Testicle Lumps/Swelling Other:
Musculoskeletal Arthritis Fractures Osteoporosis	Joint Swelling Pain: Back Joint Limb Muscle Neck Bone Other:
Skin	
	Hives Itchy Skin Surgical Incision Masses Rashes Skin Changes Other:
Psychiatric Anxiety or Panic Disorder Depression PTSD (Post-Traumatic Stress Disorder)	Other:



Patient Name:			DOB	<u>:</u>	
Wellness Questionnaire		please ma	ark your ans	swers below	,
Over the last 2 weeks, how often I bothered by the following problems:	•	Not at all	Several days	Over 50% of the days	Nearly every day
Feeling nervous, anxious, or on ed	ge	0	0	0	0
Inability to stop or control worrying		0	0	0	0
Little interest or pleasure in doing things		0	0	0	0
Feeling down, depressed, or hopeless		0	0	0	0
Are there any additions	al resources tha	nt you wou	ld like to	discuss?	
	please circle be	elow			
Support Groups	Lodging		Home	Health	
Transportation	Insurance		Other:_		



Patient Name:	DOB:
(1	Medical Record Release Full Disclosure of Health Information for Treatment and Quality of Care)
medical treatm	nat my choice on whether to sign this form will not affect my ability to get nent, payment for medical treatment, health insurance enrollment, or eligibility y signing this form, I voluntarily authorize, give my permission and allow use :
Of What:	All my health information from Whom: All information sources. Including any details regarding sensitive conditions (if any).
To Whom:	Ackerman Cancer Center Amelia Island Office 1340 South 18th Street, Ste 103 Phone: 904-277-2700 Fernandina Beach, FL 32034 Fax: 904-277-2220
Purpose:	To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.
Effective Period:	This form will remain in effect during my lifetime or until the day that I withdraw my permission.
Revoking My Permission:	I can revoke my permission at any time by giving written notice to the Ackerman Cancer Center.
information I understar to other pe I understar that is other	the use of a copy (including electronic copy) of this form for the disclosure of the n described above. Ind that there are some circumstances in which this information may be re-disclosed ersons. Ind that refusing to sign this form does not stop disclosure of my health information erwise permitted by law without my specific authorization or permission. If all pages of this form and agree to the disclosures above from the types of sources

Date

Relationship to Patient

Patient/Representative Signature

Representative Name if Applicable (please print)



Patient Name:	DOB:
Ge	neral Consents
	s at Ackerman Cancer Center. These services may s, PET-CT scans, mammograms, diagnostic x-rays,
,	offered elsewhere in the community. Please check with t of facilities that offer these services if you would like
Center. By signing below, I indicate I ar	tion, such as text or email, from Ackerman Cancer in the person legally responsible for all use of mobile age, and that I agree to all terms and conditions of
	To opt out any time, call 904-880-5522 and speak esentative. Text messages are not a substitute for
body with the consent of my physician. unless my physician believes that this i research, education, or science. I hereb	oto, video, and/or audio) made of me or parts of my This imaging shall be used in my medical record only nformation could be beneficial for use in medical by relinquish any property rights in any photography, shed. I understand that I will not receive payment fron
Contact Information Change I consent that I am responsible for noti information changes.	fying Ackerman Cancer Center when my contact
Refusal to consent to any of the above way. I have read and agree to the abov	will not affect the medical care I will receive in any ee consents.

Date

Relationship to Patient

Patient/Representative Signature

Representative Name if Applicable (please print)



Patient Name:	DOB:

Notice of Privacy Practices | HIPAA

As stated in the Ackerman Cancer Center Notice of Privacy Practices, we may disclose your health information to a member of your family, a relative, a close friend, or and other person whom you identify. This form is effective for the lifetime of the patient or until permission is withdrawn via written notice to Ackerman Cancer Center.

Please print below the people/persons to whom you give authorization to disclose your health information.

Name	Relationship to Patient	Phone Number
I have read and agree	to the Notice of Privacy Practi	ices
Thave read and agree	To the Nonce of Thirdey Trach	rees.
Patient/Representative Signature		Pate
Representative Name if	Applicable (please print) R	Relationship to Patient



Patient Name:	DOB:

Financial Responsibility Form

We are committed to providing our patients with the highest quality care. Please read and sign this form to acknowledge your understanding of our patient financial policies. This form is effective for the lifetime of the patient or until permission is withdrawn via written notice to Ackerman Cancer Center.

I hereby authorize assignment of financial benefits directly to Ackerman Cancer Center and its associate healthcare entities for medical services. I understand that I am financially responsible for charges not covered by this assignment. If my insurance carrier denies or does not cover my claim for medical services provided to me, I acknowledge that I assume full financial responsibility for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage. I understand that co-payments are due at time of service.

I have read and understand this Financial Responsibility Form described above. I agree to pay on time and in full amounts due to Ackerman Cancer Center for all items and services.

COVID-1	9 Information	
	ving from Ackerman Cancer Center are: <i>indicate below)</i>	
COVID-related	Non-COVID-related	
For patients receiving COVID-related healthcare services: Pursuant to the Family First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), your health insurance plan is responsible for covering 100% of these services and you should not be responsible for any cost-sharing obligation.		
Patient/Representative Signature	Date	
Representative Name if Applicable (pleas	se print) Relationship to Patient	