ACKERMAN Cancer Center

Patient Information

Last Name:	First Name:	MI:	Salutation:
Date of Birth:	SSN:	Referring Physician:	
Is this your legal name? ◯Y ◯N	If not, what is your legal name?	Former Name:	
Marital Status:	Sex:	Gender:	Pronouns: *(please circle)* ☐She/Her ☐He/Him ☐They/Them
Street Address:	City:	State:	Zip:
PO Box: *(if applicable)*	Email Address:		
Home Phone:	Cell Phone:	Work Phone: *(or other number)*	
Employment Status: *(please circle)* ☐Full-Time ☐Part-Time ☐Retired	Employer:	Occupation:	
Preferred Contact Method: *(please circle)* ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email ☐Text		Preferred Language:	

In Case of Emergency

Emergency Contact Name:	Relationship to Patient:
Phone Number:	Other Phone Number: *(please specify)*

If the Patient is *not* 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

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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 physicians
(e.g. Cardiologist, Internist, Pulmonologist, Oncologist, etc.)

Doctor's Name	Specialty

Demographic Data

Collection of the following information is encouraged by federal health agencies.
This information is used to monitor & improve 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

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Patient Name: DOB:

Reason For Visit:

Are you experiencing pain today? If so, please indicate below:

no pain *unbearable pain*

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Cancer History *(please mark all that apply)*

Type	N/A	Self	Mother	Father	Sibling(s)	Grandparents		Other	Comments
						Maternal	Paternal		
Lung									
Breast									
Prostate									
Colorectal									
Head & Neck									
Skin									
Gynecological									
Other:_____									
Are you of Ashkenazi Jewish Descent? ○Y ○N									

Surgical History/Major Hospitalizations

Procedure	Date (MM/YYYY)	Surgeon/Hospital	Reason/Complications

Social History

	Yes	No	Quit	Comments
Do you drink alcohol?				Drinks per week:_____
Do you smoke tobacco?				Years smoked:_____ Packs per day:_____
Do you use illegal drugs or controlled substances?				
Weekly exercise routine?				
Describe your typical diet:				

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Medication List

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

Exams & Vaccines

Please list the dates and results of any of the following that you may have had

Type	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:_____		

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Patient Name: DOB:

Review of Systems

Medical History	Current Symptoms
Please circle all that apply	*Please circle all that apply*
General	
	☐ 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 ☐ Stroke	☐ Chest Pain ☐ Elevated Cholesterol ☐ *Pacemaker* ☐ Fainting ☐ Recent Change in Exercise Tolerance ☐ Leg Swelling ☐ Other:
Hematologic/Lymphatic	
☐ Anemia ☐ Bleeding Disorder ☐ Blood Transfusion	☐ Abnormal Bleeding ☐ Abnormal Bruising ☐ Other:
Respiratory	
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis	☐ Wheezing ☐ Chest Congestion ☐ *Oxygen Use* ☐ Shortness of Breath **Cough:** ☐ Productive ☐ Nonproductive ☐ Other:

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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:

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Patient Name: DOB:

Wellness Questionnaire

please mark your answers below

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over 50% of the days	Nearly every day
Feeling nervous, anxious, or on edge	○	○	○	○
Inability to stop or control worrying	○	○	○	○
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○

Are there any additional resources that you would like to discuss?

please circle below

☐ Support Groups ☐ Lodging ☐ Home Health

☐ Transportation ☐ Insurance ☐ Other:_____

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Patient Name: _____ **DOB:** _____

Medical Record Release

(Full Disclosure of Health Information for Treatment and Quality of Care)

I understand that my choice on whether to sign this form will not affect my ability to get medical treatment, payment for medical treatment, health insurance enrollment, or eligibility for benefits. By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

Of What: All my health information including any details regarding sensitive conditions (if any).

From Whom: All information sources.

To Whom: Ackerman Cancer Center | *Jacksonville Office*

10881 San Jose Boulevard
Jacksonville, FL 32223

Phone: 904-880-5522
Fax: 904-880-5533

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.

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other persons.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

Patient/Representative Signature _____ **Date** _____

Representative Name if Applicable *(please print)* _____ **Relationship to Patient** _____

Patient Name: DOB:

General Consents

Diagnostic Services

I consent to receive diagnostic services at Ackerman Cancer Center. These services may include, but are not limited to, CT scans, PET-CT scans, mammograms, diagnostic x-rays, MRIs, and ultrasounds.

Many of these diagnostic services are offered elsewhere in the community. Please check with our front desk to obtain an updated list of facilities that offer these services if you would like to obtain them elsewhere.

Digital Communication

I consent to receive digital communication, such as text or email, from Ackerman Cancer Center. 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 of text messaging services.

Message and/or data rates may apply. To opt out any time, call 904-880-5522 and speak with an Ackerman Cancer Center representative. Text messages are not a substitute for professional or medical attention.

Medical Imaging

I consent to have medical imaging (photo, video, and/or audio) made of me or parts of my body with the consent of my physician. This imaging shall be used in my medical record only, unless my physician believes that this information could be beneficial for use in medical research, education, or science. I hereby relinquish any property rights in any photography, video, and/or audio taken and/or published. I understand that I will not receive payment from any party.

Contact Information Change

I consent that I am responsible for notifying Ackerman Cancer Center when my contact information changes.

Refusal to consent to any of the above will not affect the medical care I will receive in any way. *I have read and agree to the above consents.*

Patient/Representative Signature	**Date**
Representative Name if Applicable *(please print)*	**Relationship to Patient**

ACKERMAN Cancer Center

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 Practices.

_____ _____

Patient/Representative Signature Date

_____ _____

Representative Name if Applicable (please print) Relationship to Patient

ACKERMAN Cancer Center

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-19 Information

The healthcare services I am receiving from Ackerman Cancer Center are:
(please indicate below)

◯ 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 *(please print)* _____ Relationship to Patient _____