

Place Label Here

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age:** _____ **Male** **Female** **SS#:** _____

Primary Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: Preferred (_____) _____

Cell Phone: Preferred (_____) _____

Secondary Address: _____

City: _____ **State:** _____ **Zip:** _____

May we leave a message on your answering machine/voicemail? **Yes** **No**

Email Address: _____ **May we email you?** **Yes** **No**

Preferred Language: _____

Ethnicity: **Hispanic/Latino** **Non-Hispanic/Latino**

Race: **Native American or Alaska Native** **Asian** **Black or African American** **Native Hawaiian or
Other Pacific Islander** **White** **Other**

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets: _____

(Internal Use Only)

MRN#: _____



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

Emergency Contact Name:

Relationship: _____ Phone: (_____) _____

Employment Status:

Employed/Self Employed Unemployed Retired Disabled

Occupation (or Former Occupation): _____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will Yes No Unknown

Durable Power of Attorney Yes No Unknown

DNR Yes No Unknown

Patient Name: _____ **DOB:** _____

Reason for this Visit: _____

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

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

Other Medical History: _____

Cancer History:

Type: _____ Date diagnosed _____

Treatment: (type, date, and location of treatment) _____

Treating Physician: _____

Patient Name: _____ **DOB:** _____

Past Surgical History: *(Please circle and date any of the surgeries and/or procedures that you have undergone)*

Coronary Bypass	Date: _____	Knee Replacement	Date: _____
Angioplasty	Date: _____	Rotator Cuff Repair	Date: _____
Pacemaker	Date: _____	Cataract	Date: _____
Cardiac Valve surgery	Date: _____	Gallbladder surgery	Date: _____
Hemorrhoidectomy	Date: _____	Hysterectomy	Date: _____
Prostate Operation	Date: _____	Prostatectomy	Date: _____
Hernia Repair	Date: _____	Appendectomy	Date: _____
Tonsillectomy	Date: _____	Hip Replacement	Date: _____
Mastectomy	Date: _____	Lumpectomy	Date: _____

Other Operations: _____

Social History:

Tobacco Use: *(Present and/or Past):*

- Never Smoked
- Quit smoking When? _____ How many years did you smoke? _____yr(s)
How many packs? _____/day
- Currently Smoke Cigarettes Pipe Cigars How many packs? _____/day
How many years? _____
- Chewing Tobacco

Alcohol History: *(Present and/or Past):*

- Non Drinker
- Beer number of bottles _____per Day Week Month
- Wine number of glasses _____per Day Week Month
- Liquor number of glasses _____per Day Week Month

Marital Status: Married Single Widowed Divorced Other

Household Status: Lives Alone Lives with Family Lives in Nursing Home
 Winter Resident Year-Round Resident

Children: Yes No Number _____

Health Maintenance:

Sigmoidoscopy / Colonoscopy: Yes No Date: _____

Findings: _____

Last Mammogram: Date: _____ Last Bone Density: Date: _____ Last Pelvic Exam: Date: _____

Influenza (Flu) Shot: Date: _____ Pneumococcal Shot: Date: _____ Last Shingles Shot: Date: _____

Last EGD: Date: _____ Last Colonoscopy: Date: _____ Last Prostate Exam: Date: _____

Patient Name: _____ **DOB:** _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:

- Weight loss
How much _____
Over what time period _____
- Fevers
- Max temp _____
- Chills
- Night sweats
- Fatigue

Eyes:

- Wear Glasses/Contact Lenses
- Blurred Vision
- Double Vision

Ears, Nose, Throat:

- Hard of Hearing or Deaf
- Ringing in Ears
- Enlarged Lymph nodes
- Chronic Sinus Problems
- Sore Throat
- Mouth Pain/Sores

Changes/Difficulty In:

- Taste
- Smell

Cardiovascular:

- Chest Pain/Angina Pectoris
- Palpitations/Heart Murmur
- Irregular Heart Beat/Pressure

Respiratory:

- Chronic or Frequent Cough
- Bloody Sputum
- Shortness of Breath

Skin:

- Rashes or Itching
- Change in Skin Color or Moles
- Varicose Veins
- Skin Cancer

Gastrointestinal:

- Difficult or Painful Swallowing
- Abdominal Pain
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Lump or Sensation in Throat
- Food Sticking
- Bloating
- Belching
- Diarrhea
- Constipation
- Rectal Bleeding
- Black or Tarry Stool
- Hidden Blood in Stool
- Excessive Rectal Gas/Flatus
- Loss of Stool/Fecal Accident
- Poor Appetite
- Jaundice

Genitourinary:

- Kidney Stones
- Pelvic Pain
- Incontinence
- Burning or Pain on Urination
- Blood in Urine
- Difficult Urination
- Men: Prostate Problems

Musculoskeletal:

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

Neurological:

- Numbness/Tingling
- Arm or Leg Weakness
- Light-Headed/Dizzy/Fainting Spells
- Tremors/Headaches

Psychiatric:

- Anxiety/Agitation
- Depression
- Crying for No Reason
- Insomnia
- Alcoholism
- Drug Problem

Hematologic:

- Easy Bruising
- Gum or Nose Bleeding
- Blood Transfusions

Endocrine:

- Heat or Cold Intolerance
- Excessive Skin Dryness
- Excessive Thirst
- Excessive Urination
- Weight Problem
- Hot Flashes

Breast:

- Rashes or Itching
- Changing in Skin Color
- Varicose Veins
- Skin Cancer
- Breast Pain/Lump
- Breast Discharge
- Breast Rash

Allergies/Immunology:

- History of Allergies
- Chronic Infections



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Patient Name: _____ DOB: _____

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

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

MEDICATION LIST

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

Drug Allergies: List all medication allergies

Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____

Are you allergic to:

- Iodine
- Latex
- Shellfish
- CT Scan Dye / IV Contrast
- Eggs
- Peanuts

Other: _____

Type of Reaction: _____



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**AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED
FOR ELECTRONIC MEDICAL RECORDS**

I authorize Partner Oncology (PO), a division of American Oncology Partners, P.A., to take my photograph (digital camera/video may be used). These photos may then be placed in my Partner Oncology (PO) electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

Patient Name (Print)

Patient or Guarantor (Signature)

Date



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

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 Partner Oncology: *(Internal use)*

Address, City, State, Zip Code

Fax/Telephone Number

_____ I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Partner Oncology (PO) 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.

_____DISCLAIMER: Not signing does not prevent me from receiving care.

Patient Name (Print)

Date

Patient Date of Birth

Patient or Guarantor (Signature)

Date



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

Please check one of the following:

I give permission to the employees of Partner Oncology, a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):

Name: _____ Relation: _____ Phone: _____

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 individual(s).

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

Patient Name (Print)

Date

Patient or Guarantor (Signature)



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

Patient Name: _____ **DOB:** _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? Yes No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? Yes No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder: _____

Policy#/Bin# _____

I certify that the information provided is accurate. I will notify Partner Oncology, a division of American Oncology Partners, P.A. of any changes as soon as they become available. I understand that it is my responsibility to update us 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)



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

Thank you for choosing Partner Oncology, a division of American Oncology Partners, P.A. (PO/AOP), as your health care provider. Our physicians are committed to providing you with the highest quality care.

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

- You agree to provide PO/AOP with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that PO/AOP will bill your insurance plan or program for services provided by PO/AOP and you agree you are assigning your right to receive payment or benefits from such insurer or program to PO/AOP and you are authorizing payment to be made directly to PO/AOP.
- You agree you are responsible for payment to PO/AOP of all copays, 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 health care providers, PO/AOP will use your personal health information internally and will share such information with your insurance policy and certain business associates of PO/AOP in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- PO/AOP owns and operates AON Pharmacy, LLC, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your PO 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 AON Pharmacy, LLC and may have your prescriptions filled wherever you choose. However, if you select AON Pharmacy, LLC to fill PO-issued prescriptions, then this policy and all other PO/AOP patient financial responsibility policies will also apply to the items and services provided to you by AON Pharmacy, LLC.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by PO/AOP clinicians at PO/AOP’s 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.
- If you make a payment to PO/AOP that results in a surplus on your account (e.g., a credit balance), PO/AOP may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and PO/AOP 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 your care a credit balance remains which is not subject to return to your insurer or other payer, PO/AOP 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.



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**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

Patient or Guarantor (Signature)

For office use:

Name (Print)

PO/AOP Employee (Signature)



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

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 Partner Oncology, a division of American Oncology Partners, P.A., or AON Pharmacy, LLC 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.

Physician Name

Insurance Name

Patient Name (Print)

Date

Patient or Guarantor (Signature)



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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 the Partner Oncology, a division of American Oncology Partners, P.A., (PO/AOP) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Partner Oncology, a division of American Oncology Partners, P.A., (PO/AOP) facility or by submitting a request in writing to the corporate office at Partner Oncology, a division of American Oncology Partners, P.A., (PO/AOP), 9160 Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting AONcology.com/policies/PO_NPP.pdf

Date: _____

Patient Name (Print)

DOB

Patient (Signature)

Date

Patient or Guarantor (Signature)

Date



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

By signing below, I authorize Partner Oncology, a division of American Oncology Partners, P.A., (PO/AOP) its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized PO/AOP 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 PO/AOP under my cell phone plan.

I know that I am under no obligation to authorize PO/AOP 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.

PLEASE MARK THE FOLLOWING:

- I consent to receiving information via text. I understand I can withdraw my consent at any time.
Text Cell # _____
- I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

Patient Name (Print)

Date

Patient (Signature)