Atlanta Cancer Care
AFFILIATED WITH
NORTHSIDE HOSPITAL CANCER INSTITUTE
BUILT TO BEAT CANCER

PATIENT INFORMATION FORM

Patient Information

Date (M/D/Y):

First Name: Mid Name: Last Name: Suffix:(JR. Sr.):

Street Address: County:

City, State & Zip: Country:

Home Phone: Cell Phone:

Email:

Can message be left: ☐ Home ☐ Cell

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐ Other

SS#:

Date of Birth (M/D/Y): SEX: ☐ Female ☐ Male

Preferred Language:

DEMOGRAPHICS: Which choice most closely reflects your individual recognition in your community? Race & Ethnicity are collected for statistical reporting to the US Government and the choices displayed are based solely on the Government Recommendations.

Race:
- ☐ American Indian or Native AK
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Pacific Islander/ Hawaiian
- ☐ Multiracial
- ☐ Unknown

Ethnicity:
- ☐ Hispanic/ Latino
- ☐ Not Hispanic or Not Latino
- ☐ Unknown

Nationality:
- ☐ American
- ☐ Brazilian
- ☐ British
- ☐ Canadian
- ☐ Chinese
- ☐ Cuban
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hispanic
- ☐ Indian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Mexican
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Saudi Arabian
- ☐ Vietnamese
- ☐ Other

Emergency Contact: Emergency Phone: Relationship:

Referring Physician: Primary Care Physician:

Do you have an Advance Directive? ☐ Yes ☐ No If no, would you like more information?

PATIENT INFORMATION FORM

Patient Employer

Occupation:

Employment Status: ☐ Full Time ☐ Not Employed ☐ Retired ☐ Disabled ☐ Part Time ☐ Self Employed ☐ Active Military

Effective Date of Employment (M/D/Y):

Retirement Date (M/D/Y):

Disabled Date (M/D/Y):

Employer/School:

Employer Address:

City, State & Zip:

Work Phone: Ext:

Other Responsible Party/ Spouse/ Significant Other

First Name: Mid Name: Last Name: Suffix:(JR. Sr.):

Relationship to Patient :

SEX: ☐ Female ☐ Male

Date of Birth (M/D/Y):

Street Address:

City, State & Zip:

Country:

Home Phone: Cell Phone: Work Phone:

Spouse Employment

Occupation:

Employment Status: ☐ Full Time ☐ Not Employed ☐ Retired ☐ Disabled ☐ Part Time ☐ Self Employed ☐ Active Military

Effective Date of Employment (M/D/Y):

Retirement Date (M/D/Y):

Employer/School:

Retirement Date (M/D/Y):

Employer Address:

City, State & Zip:

Work Phone: Ext:

Patient Insurance Information

First Name: Mid Name: Last Name: Suffix:(JR. Sr.):

SS#: Date of Birth (M/D/Y):

PATIENT INFORMATION FORM

First (Primary) Insurance Information

Carrier/Plan Name:

Group Name: Group Phone Name: Ext:

Group Number: Policy Number:

Claims Address: (back of insur. card)

City, State & Zip:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SEX: ☐ Female ☐ Male

Insured's Name: (as printed on card):

Date of Birth (M/D/Y):

SS#:

☐ HMO ☐ PPO ☐ POS

Payor ID (EDI#):

Second (Secondary) Insurance Information

Carrier/Plan Name:

Group Name: Group Phone Name: Ext:

Group Number: Policy Number:

Claims Address: (back of insur. card)

City, State & Zip:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SEX: ☐ Female ☐ Male

Insured's Name: (as printed on card):

Date of Birth (M/D/Y):

SS#:

☐ HMO ☐ PPO ☐ POS

Payor ID (EDI#):

Third (Tertiary) Insurance Information

Carrier/Plan Name:

Group Name: Group Phone Name: Ext:

Group Number: Policy Number:

Claims Address: (back of insur. card)

City, State & Zip:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SEX: ☐ Female ☐ Male

Insured's Name: (as printed on card):

Date of Birth (M/D/Y):

SS#:

☐ HMO ☐ PPO ☐ POS

Payor ID (EDI#):

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Patient Health History

Name: DOB:

Age:

Past Medical History:

Please check all that apply:

- ☐ Anemia
- ☐ Bleed/Bruise easily
- ☐ Blood Clots/Phlebitis
- ☐ Cancer
- ☐ Enlarged lymph nodes
- ☐ Stroke
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Thyroid disorders
- ☐ Hives or Eczema
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Circulatory Problems
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart rhythm problems
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure (Hypertension)
- ☐ Low Blood Pressure
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Kidney problems
- ☐ Urinary infections
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Ulcers
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Emotional Problems
- ☐ Substance abuse

Infections:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping cough
- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Small pox
- ☐ Tuberculosis
- ☐ Rheumatic fever
- ☐ Infectious mono
- ☐ AIDS or HIV
- ☐ Venereal Disease

☐ Other: _____

Past Surgical History:

- ☐ Never had Surgery
- ☐ Had Surgery

Reason for Surgery	Location:	Date:

Procedures:

- ☐ Never had a colonoscopy
- ☐ Had a colonoscopy. Date:_____
- ☐ Had other colorectal cancer screening. Test:_____Date:_____

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Patient Health History

Name: _____ DOB: _____

Gynecologic History:

*Are you Pregnant: Y / N
Number of pregnancies(Gravida): _____
Number of deliveries(Para): _____
Age at first Birth: _____
# of interrupted pregnancies: _____
Miscarriages: _____
Abortions: _____

Age at first period: _____
Age at menopause: _____
☐ Hormone Use
☐ Contraceptive Use # years _____
☐ Post Menopausal Use # years _____
☐ Other Hormone Use # years _____

Date of last PAP: _____
Date of last Mammogram: _____

Family History:

Biological Father
Age: _____
☐ Living ☐ Deceased ☐ Unknown
Cause of Death: _____
Medical Problems: _____

Biological Mother
Age: _____
☐ Living ☐ Deceased ☐ Unknown
Cause of Death: _____
Medical Problems: _____

Biological Brother(s)
# of living brothers: _____ Age(s): _____
# of deceased brothers: _____ Age(s): _____
Cause of Death: _____
Medical Problems: _____

Biological Sister(s)
# of living sisters: _____ Age(s): _____
# of deceased sisters: _____ Age(s): _____
Cause of Death: _____
Medical Problems: _____

Biological Children
# of living sons: _____ daughters: _____
# of deceased sons: _____ daughters: _____
Cause of Death: _____
Medical Problems: _____

Other Family Problems include:

_____

_____

Social History:

Marital Status:
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Smoking Status:
☐ Yes - every day smoker
☐ Yes - some day smoker
☐ Yes - but Quit
☐ Never
☐ Smoker - status unknown
☐ Heavy tobacco smoker (> 10 cig/day or cigars)
☐ Light tobacco smoker (<10 cigs/day)

# of years: _____
Packs/Day: _____
of Years Quit: _____

Alcohol Consumption:
☐ Yes - every day drinker
☐ Yes - some day drinker
☐ Yes - but Quit
☐ Never
Days/Week: _____
Drinks/Day _____
of Years Quit: _____

Occupation: _____

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Review of Systems

DOB:

Constitutional Symptoms
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Loss of appetite
- ☐ Fever/Chills
- ☐ Night sweats
- ☐ Fatigue
- ☐ Headache

Skin
- ☐ Rash
- ☐ Itching
- ☐ Changes in skin color
- ☐ Changes in hair or nails
- ☐ Changes in Mole(s)
- ☐ Varicose veins

Eyes
- ☐ Visual Problems
- ☐ Blurred or double vision
- ☐ Eye Disease or Injury
- ☐ Wear glasses/contact lenses

Ears/Nose/Throat/
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat
- ☐ Voice Changes

Heart/Lungs
- ☐ Chest pain
- ☐ Palpitations
- ☐ Short of breath
- ☐ Short of breath at night
- ☐ Short of breath
  - worse with exertion
- ☐ Cough
- ☐ Cough up blood
- ☐ Swelling in legs, feet, or hands
- ☐ Wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Abdominal pain
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Painful bowel movements
- ☐ Rectal bleeding/blood in stool
- ☐ Special Diet

Urinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Lack of control/incontinence
- ☐ Blood in urine
- ☐ Kidney Stone

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Muscle pain/swelling
- ☐ Back pain
- ☐ Bone pain
- ☐ Difficulty walking
- ☐ Cold extremities

Neurological/Emotional
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Jerking/twitching
- ☐ Numbness/tingling
- ☐ Anxiety
- ☐ Depression
- ☐ Fainting Spells
- ☐ Confusion
- ☐ Memory loss
- ☐ Insomnia

Endocrine
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Thyroid condition

Gynecological
- ☐ Vaginal bleeding
- ☐ Changes in Menses
- ☐ Discharge

Length of last menses: _____

Comments:

_____

_____

_____

_____

_____

_____

_____

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Atlanta Cancer Care
Current Medications Survey

Dear Patient,

In order to ensure that we have current information regarding medications that you use, please complete the following for all medications and vitamins that you currently take on a regular basis, or once in a while as needed. This should include all prescription and over the counter products recommended by any provider. Please also provide allergy and pharmacy information.

PATIENT NAME AND BIRTHDATE (print):_____

Pharmacy name and phone number:_____

Allergies: I am not allergic to any foods or medications ☐

What are you allergic to?	When was your first allergic reaction to this?	What happened during the allergic reaction?	Mild, moderate, or severe reaction?

Drug Name	Strength	Dose You Take	How Often	Date Started	Reason for taking medication

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EMERGENCY CONTACT INFORMATION

Date: _____ Patient Name: _____

DOB: _____

Contact Name: _____ Relationship: _____

Phone: (home)_____ (cell) _____

Contact Name: _____ Relationship: _____

Phone: (home) _____ (cell) _____

Contact Name: _____ Relationship: _____

Phone: (home) _____ (cell) _____

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HIPAA RELEASE

I _____, hereby do give permission to Atlanta Cancer Care to discuss my medical case with the following persons:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

The following are persons whom I specificially <u>DO NOT</u> wish my case to be discussed with:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

PATIENT SIGNATURE : _____ DATE: _____