PATIENT INFORMATION

DATE	AGE	BIRTH DATE	SOCIAL SECURITY NO.

PATIENT NAME:	PHONE: Is it OK for us to leave messages? Yes No
ADDRESS	MOBILE: Yes No

CITY	STATE	ZIP CODE	E-MAIL ADDRESS

SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ OTHER ☐ _____

LIST OF PEOPLE (NAME & RELATIONSHIP) WITH WHOM WE MAY SHARE YOUR MEDICAL INFO:

INSURANCE COVERAGE #1 (Primary)

INSURANCE CO NAME

INSURED'S NAME

ID#	GROUP#	CO-PAY? No: Yes: Amount $:

INSURED THROUGH: SELF ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐

INSURANCE COVERAGE #2 (Secondary)

INSURANCE CO NAME

INSURED'S NAME

ID#	GROUP#	CO-PAY? No: Yes: Amount $:

INSURED THROUGH: SELF ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE
SPOUSE'S/PARENT'S EMPLOYER	OCCUPATION	WORK PHONE

FRIEND/RELATIVE CONTACT NAME	FRIEND ☐ RELATIVE ☐ _____
FRIEND/RELATIVE ADDRESS	FRIEND/RELATIVE PHONE

REFERRED BY	FAMILY DOCTOR NAME	DOCTOR PHONE

ASSIGNMENT OF BENEFITS - I hereby authorize assignment and payment of major medical benefits due me to NW Surgical Oncology, PC. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. **I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.**

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION - I hereby authorize NW Surgical Oncology, PC to release any information requested by my insurance company, or to release information to any hospital or to any physician I may be referred to by this office.

Signature _____ Date _____

Effective Date 1/1/2007

NOTICE REGARDING PATIENT PRIVACY

NW Surgical Oncology, PC is committed to preserving the privacy of your personal health information. In addition, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use or disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current notice in effect.

If you have questions, concerns, or complaints about the notice or your medical information, please contact the office manager at 503 517 9030.

Please sign to acknowledge that you have received a copy of this notice. We will retain this in our records.

_____ _____

Patient or Guardian Signature Date

NW Surgical Oncology, PC

Individual Medical History

Please note that we will keep your health information confidential and strictly guarded. It will be used solely in conjunction with taking care of you.

PATIENT NAME: _____

DOB: _____

Please list any operations you have had and the approximate year they were performed:

Please list any recent hospitalizations, their dates, and the reason:

Please list any <u>chronic health</u> issues you have such as high blood pressure, diabetes, heart disease, hepatitis, etc

Please list any cancer you've had and treatment performed (ex. surgery, radiation &/or chemo therapy)

Please list any medications, herbal supplements, or over the counter remedies, or vitamins you take on a regular basis with their doses and the number of times a day you take them:

Medication	Dose	# per day	Medication	Dose	#per day

PATIENT NAME: _____
DOB: _____

Please list any medications or other substances you are allergic to and what happens when you are exposed to that substance:

Allergic to: medication, substance, food	Reaction

How many alcoholic drinks per week do you average? _____
Have you ever had withdrawal symptoms from alcohol? **YES/NO**

Have you ever used tobacco products? **YES/NO**
If yes, please estimate the amount used on a daily basis, number of years and when you quit
for example: 1 pack cigarettes per day for 10 years, quit in 1991_____

Have you ever used illegal IV drugs? **YES/NO**
If yes, when was last time? _____
Do you live with anyone else or have access to help at home? **YES/NO**
What is your profession? _____
Have you had exposure to any toxic chemicals or radiation ? **YES/NO**
If yes, explain _____

Health Screening
Have you ever had a colonoscopy? **YES/NO** Date of last one? _____
Was it normal? **YES/NO**

If applicable, date of last mammogram? _____ Was it normal? **YES/NO**

Personal Breast Cancer Risk Factors:
For Women: Age of 1st period: _____ years Date last menstrual period:_____
Are you in or have you gone through menopause? **YES/NO**
Age at first live birth: _____ years Did you breast feed? **YES/NO**

Family History
Does or did any member of your blood relations have cancer of any kind? **YES/NO**
If yes, what type of cancer and how are you related? _____

Please list the ages of your parents if they are alive and if they are healthy, or the age at which they died.

	Healthy/ if not explain below	**Age**	**Age at time of death**
Mother	**YES/NO**	____	_____
Father	**YES/NO**	____	_____

Please list parent's health problems _____

Do you have any siblings? **YES/NO**
If so, do they have any serious health problems **YES/NO**
How many children do you have?
Do they have any serious health problems? **YES/NO**

PATIENT NAME: _____

DOB: _____

REVIEW OF SYSTEMS: Place a **check** in the box near any **new symptoms** you are having.

☐	New rashes, discoloration of skin, or changes to existing moles
☐	Excessive dryness or flaking of skin
☐	Excessive or unexplained bruising
☐	Swollen lymph nodes
☐	New or changing lumps on body
☐	New trouble with vision example: blurring, double vision, tunnel vision
☐	New trouble hearing
☐	Differences in how food normally tastes
☐	Trouble swallowing
☐	Changes in appetite
☐	Numbness or tingling of extremities
☐	Abnormal feeling of fullness after eating
☐	Weight loss or gain
☐	New or excessive headaches
☐	Yellowing of the whites of the eyes
☐	Jaundiced skin
☐	Trouble breathing at rest or with light activity
☐	Increased fatigue
☐	Racing heart or palpitations
☐	Chest pain, angina
☐	Constipation
☐	Diarrhea
☐	Abdominal pain
☐	Blood in stool or dark tarry stool
☐	Cramping of legs with activity
☐	Swelling in legs
☐	Trouble sleeping
☐	Depression

Patient Signature: _____ **Date:** _____

For physician notes only

Physician Notes: _____