ACKERMAN™
Cancer Center

Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN: _____ Gender: _____

Home Phone: _____ Mobile Phone: _____

Preferred Phone: ☐Home ☐Mobile Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ ☐Part-Time ☐Full-Time ☐Retired

Employer: _____

If patient is not the policyholder, please provide their Social Security Number and Date of Birth for billing purposes.

Name: _____ DOB: _____ SSN: _____

Signature: _____

How did you find us? Check all that apply

☐Family/ Friend ☐Print ☐Billboard
☐Physician ☐Radio ☐Community Event
☐Online Search ☐Television ☐Drive-By
☐None Apply ☐Other: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

☐Not Hispanic or Latino
☐Hispanic or Latino
☐Decline Response

Race:

☐American-Indian or Alaska Native
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White
☐Asian
☐Other
☐Decline Response

Preferred Language: _____ ☐Decline Response

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Physician Information

Primary Care Provider (PCP): _____ PCP Phone: _____

Preferred Pharmacy: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone: _____ Referring Provider: _____

Reason for today's visit? _____

Please list ALL active treating physicians (i.e.Pulmonologist, Oncologist, Internist, Cardiologist, etc.)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

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Cancer Center

Chief Complaint

Patient Name: _____ DOB: _____

Gender: _____ Race: _____

Medical History

History of Cancer: (Please list type and date of any treatments or procedures)

_____

_____

Have you ever had any of the following? (Check only if applicable)

Asthma/Breathing Problems..... ☐
Arthritis..... ☐
Bleeding/ Clotting Disorder..... ☐
Blood Pressure Disorder..... ☐
Blood Transfusion..... ☐
Bowel/Stomach Problems..... ☐
Cholesterol Disorder..... ☐
Diabetes..... ☐
Eye Disorder (i.e. Glaucoma, cataract)..... ☐
If relevant: Gynecological Issues..... ☐

Heart Disease/Disorder..... ☐
Lung Disorder..... ☐
Liver Disease..... ☐
Neurological Disorder/Chronic Headaches..... ☐
Psychiatric Disorder/Illness..... ☐
Stroke..... ☐
Seizure or Epilepsy..... ☐
Thyroid Disorder..... ☐
Urinary/Kidney Disorder..... ☐

Please list any other medical illnesses or problems and provide details for any of the conditions above:

_____

_____

Surgical History

Please list all past surgeries and hospitalizations and the approximate date:

Procedure / Hospitalization	Date	Complications

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Cancer Center

Patient Name: _____ DOB: _____

Please complete this form to the best of your knowledge. If there are details you do not know, please leave the box empty.

Family History

Relationship	Any known cancer history:	Alive (Y/N)
Mother		
Father		
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		
Sister		
Brother		
Please list any other close blood relatives with a history of cancer:		

Do you currently smoke? ☐Y ☐N If no, previously? ☐Y ☐N

Years smoked _____ Packs/Day_____ Do you use other tobacco products? ☐Y ☐N

Consume alcohol? ☐Y ☐N If yes, drinks/week? _____

If relevant: Any past pregnancies? ☐Y ☐N How many? ____ How many deliveries? _____

Currently pregnant? ☐Y ☐N

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Patient Name: _____ DOB: _____

Allergy & Medication

Do you have any allergies to medications or other substances (pets, food, etc.) ? ☐ Y ☐ N

If yes, please list allergies and reactions (Including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

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Patient Name: _____ DOB: _____

Review of Symptoms

Reason for visit: _____

Please indicate ALL that you have experienced within the past 6-12 months. (Check only if applicable)

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Feeling Poorly
- ☐ Sleep Sweats
- ☐ Disturbance
- ☐ Weight Gain (lbs)
- ☐ Weight Loss (lbs)
- ☐ Unexpected Weight Change

☐ Note: _____

Skin

- ☐ Rash
- ☐ Dry Skin
- ☐ Skin Cancer
- ☐ Skin Wound
- ☐ Change in a mole
- ☐ Surgical Incision
- ☐ Unusual
- ☐ Growth Itching

☐ Note: _____

Head, Eyes, Ears, Nose, and Throat

- ☐ Vision Problem
- ☐ Vertigo
- ☐ Congestion
- ☐ Dentures
- ☐ Sore Throat
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Alterations in taste
- ☐ Ringing in Ears
- ☐ Decreased
- ☐ Hearing Ear Ache

☐ Note: _____

Breast

- ☐ Pain
- ☐ Nipple Discharge
- ☐ Skin Changes
- ☐ Rash
- ☐ Nipple Inversion

☐ Note: _____

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Patient Name: _____ DOB: _____

Respiratory

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Rapid Breathing
- ☐ Wheezing
- ☐ Chest Congestion
- ☐ Coughing up Blood
- ☐ Coughing up Sputum
- ☐ Oxygen Tank

☐ Note: _____

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Pacemaker
- ☐ Cold Extremities
- ☐ Irregular Heart Rhythm
- ☐ Leg Swelling
- ☐ Hypertension

☐ Note: _____

Hematologic/Lymphatic

- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Bleeding Disorder

☐ Note: _____

Endocrine

- ☐ Excessive Thirst
- ☐ Cold Intolerance
- ☐ Thyroid Disorder
- ☐ Heart Intolerance
- ☐ Changes-Hair
- ☐ Diabetes
- ☐ Changes-Skin
- ☐ Thyroid Cancer

☐ Note: _____

Psychiatric

- ☐ Depression
- ☐ Anxiety

☐ Note: _____

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Patient Name: _____ DOB: _____

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Heartburn
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bowel Incontinence
- ☐ Sores in mouth
- ☐ Black/Tarry Stools
- ☐ Decreased Appetite
- ☐ Change in Bowels
- ☐ Rectal Pain

☐ Note: _____

Genitourinary

- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Urinary Urgency
- ☐ Painful Urination
- ☐ Heavy Period Bleeding
- ☐ Pelvic Pain Urinary
- ☐ Hesitancy
- ☐ Genital Itching
- ☐ Change in Libido
- ☐ Waking at night to urinate or Frequent urination at night
- ☐ Painful Intercourse
- ☐ Discharge-Vaginal
- ☐ Vaginal Bleeding
- ☐ Irregular Monthly Cycles

☐ Note: _____

Musculoskeletal

- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Limb Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Leg Swelling

☐ Note: _____

Neurological

- ☐ Headache
- ☐ Dizziness
- ☐ Seizures
- ☐ Poor Coordination
- ☐ Memory Lapses/Loss
- ☐ Tremor
- ☐ Disorientation
- ☐ Confusion
- ☐ Numbness
- ☐ Tingling Decreased
- ☐ Strength
- ☐ Fainting (Syncope)
- ☐ Unsteadiness

☐ Note: _____

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Cancer Center

Patient Name: _____ DOB: _____

Patient Health Questionnaire - 4

Over the last 2 weeks, how often have you been bothered by the following problems? (Use a circle to indicate your answer)	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Are there any additional resources you would like to discuss?
(Please check the appropriate box or boxes)

- ☐ Support groups
- ☐ Lodging
- ☐ Transportation
- ☐ Home health
- ☐ Insurance
- ☐ Other: _____

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Cancer Center

MEDICAL RECORD RELEASE

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

Please read the entire form, both pages, before signing below

Patient (name and information of person whose health information is being disclosed):

Name: _____ DOB: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or 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 information about sensitive conditions (if any) [See page 4 for details]

FROM WHOM: All information sources [See page 4 for details]

TO WHOM: Ackerman Cancer Center
10881 San Jose Blvd.
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 authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

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 redisclosed to other persons. [See page 2 for details]
- I understand that refusing to sign this form does not stop disclosure of my health infromation that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this from and agree to the disclosures above from the types of sources listed.

Print Name of Patient or Patient Legal Representative:_____

Signature of Patient or Patient Legal Representative: _____

Personal Representative (explain: _____)

Date Signed: _____

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

ACKERMAN™
Cancer Center

Patient Name: _____ DOB: _____

Consents

Please initial next to each statement. Your initial indicates you give consent and acknowledge to having read the following:

Initials

Diagnostic Services

____

At Ackerman Cancer Center, we provide a number of diagnostic services that 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, and there are alternate facilities who can furnish similar services. If you wish to have these diagnosic services done elsewhere, please check with our front desk to obtain an updated list of facilities that offer these services.

Initials

Photography Consent

____

I consent that photographs, videotapes or other types of media to preserve images and/or sounds may be taken of me or parts of my body, under the following conditions:

1. May be taken only with the consent of my physician.

2.May be taken by my physician or by a competent photographer, approved by my physician.

3.Photographs shall be used for medical records only, unless in the judgement of my physician, medical research, education or science will be benefited by their use.

I hereby relinquish any property rights in any photographs, videotapes and/or images and sounds taken and/or published.

I have read and agree to the above consents.

Patient/Representative Name (Print): _____

Patient/Representative Signature: _____

ACKERMAN™
Cancer Center

Patient Name: _____ DOB: _____

Please initial next to each statement. Your initial indicates you give consent and acknowledge to having read the following:

Initials

Notice of Privacy Practices: HIPAA

I have reviewed the Notice of Privacy Practices from Ackerman Cancer Center.

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 any other person that you identify.

Print below, the people/persons that you give authorization to disclose your health information to.

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read and agree to Notice of Privacy Practices.

Patient/Representative Name (Print): _____ Date: _____

Patient/Representative Signature: _____

ACKERMAN™
Cancer Center

EXPLANATION OF FORM FLORIDA

AHCA FC4200-004
"Universal Medical Record Release for Full Disclosure of Health Information for Treatment and Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

OF WHAT: Includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All records and other information regarding your health history, treatment, hospitalization, tests and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes psychotherapy notes as defined in HIPAA at 45 CFR 164.501)
    c. Sickle sell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. Copies of educational tests or evaluations, including individualized educational programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. Information created before or after the date of this form.

FROM WHOM: Includes: All information sources including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

PURPOSE: Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

REVOCATION: You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

RE-DISCLOSURE INFORMATION: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful redisclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

LIMITATIONS OF THIS FORM: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your healthcare provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

ACKERMAN Cancer Center

Mammography Questionnaire

Name: _____ MR# _____ DOS: _____

DOB: ____/____/_____ Age: _____ Physician: _____

Date/Location of previous Mammogram/Breast Ultrasound:

_____

Reason for today's exam *(check)* : ☐ **ROUTINE** ☐ **FOLLOW-UP** ☐ **CALL-BACK** ☐ **NEW PROBLEM**
OTHER _____

CURRENT PROBLEMS

Lump	Both	Notes: _____
Pain	Both	Notes: _____
Nipple Discharge	Both	Notes: _____
Nipple Inversion	Both	Notes: _____
Skin Dimpling	Both	Notes: _____
Other		Notes: _____

PREVIOUS BREAST PROCEDURES

(List dates and other relevant information)

Aspirations	Both	Notes: _____
Biopsy	Both	Notes: _____
Lumpectomy	Both	Notes: _____
Radiation	Both	Notes: _____
Mastectomy	Both	Notes: _____
Reduction	Both	Notes: _____
Implants	Both	Notes: _____

PERSONAL/FAMILY HISTORY

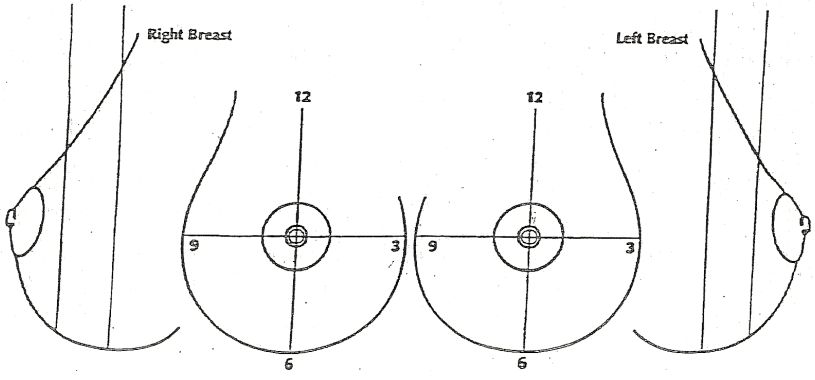
Are you pregnant? Any chance of being pregnant?	☐ NO	☐ YES	If yes, please inform technologist immediately!
Personal history of breast or ovarian cancer?	☐ NO	☐ YES	Notes: _____
Family history of breast or ovarian cancer?	☐ NO	☐ YES	Notes: _____
Do you examine your breasts regularly?	☐ NO	☐ YES	Notes: _____
Are you taking hormones or birth control pills?	☐ NO	☐ YES	Notes: _____
Do you still have periods (menses)?	☐ NO	☐ YES	If yes, when was your last period? _____

Any other relevant history, concerns, or questions?

_____

_____

Patient Signature: _____ **Date:** _____



Technologist's Notes:

_____

_____

_____

NAME: _____ MR: _____

ACKERMAN Cancer Center

DOB: _____ SSN: _____

REQUEST FOR MAMMOGRAPHY RECORDS

Please note that by signing this document it will allow us to request your prior records for the radiologist to use as a comparison to your exam that will be performed today. Make sure all the information is correct before signing.

I, _____, request that my medical records be released to:

<u>ATTENTION:</u> VIVIENNE

ACKERMAN CANCER CENTER

10881 SAN JOSE BLVD

JACKSONVILLE, FL, 32223

PHONE: (904) 880-5522

FAX: (904) 880-5533

Please send a DISK for images done on DIGITAL EQUIPMENT as well as all REPORTS.

Prior Facility: _____ Fax: _____

Signature: _____ Date: _____

A copy of this document may be used in lieu of the original

NAME: _____ MR: _____

ACKERMAN Cancer Center

DOB: _____ SSN: _____

REQUEST FOR MAMMOGRAPHY RECORDS

Please note that by signing this document it will allow us to request your prior records for the radiologist to use as a comparison to your exam that will be performed today. Make sure all the information is correct before signing.

I, _____, request that my medical records be released to:

ATTENTION: Charlotte

ACKERMAN CANCER CENTER

Medical Office Building A

1340 South 18th St., Suite 103

Fernandina Beach, FL, 32034

PHONE: (904)277-2700

FAX: (904) 277-2220

Please send a DISK for images done on DIGITAL EQUIPMENT as well as all REPORTS.

Prior Facility: _____ Fax: _____

Signature: _____ Date: _____

A copy of this document may be used in lieu of the original