

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: <i>(please circle)</i> She/Her He/Him They/Them		
Street Address:		City:		State:	Zip:
PO Box: <i>(if applicable)</i>	Email Address:				
Home Phone:		Cell Phone:		Work Phone: <i>(or other number)</i>	
Employment Status: <i>(please circle)</i> Full-Time Part-Time Retired		Employer:		Occupation:	
Preferred Contact Method: <i>(please circle)</i> 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: <i>(please specify)</i>

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? <i>(please circle)</i>				
Living Will	Power of Attorney	Healthcare Proxy	Advance Directive	N/A

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	

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:				

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:_____		

Patient Name: _____

DOB: _____

Review of Systems

Medical History	Current Symptoms			
<i>Please circle all that apply</i>	<i>Please circle all that apply</i>			
General				
	Fever	Fatigue	Night Sweats	
	Chills	Weakness	Weight Change	
	Other: _____			
Neurological				
Migranes	Headaches	Poor Coordination	Numbness/Tingling	
Seizures	Dizziness	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	Vision:	Blurry	Changes	Contacts or Glasses
Glaucoma		Double	Light Intolerance	
Macular Degeneration	Other: _____			
Endocrine				
Diabetes	Excessive Thirst		Cold or Heat Intolerance	
Thyroid Disorder	Other: _____			
Cardiovascular				
Congestive Heart Failure	Chest Pain	Elevated Cholesterol	Pacemaker	
Heart Disease	Fainting	Recent Change in Exercise Tolerance		
Hypertension	Leg Swelling			
Murmurs				
Palpitations				
Stroke	Other: _____			
Hematologic/Lymphatic				
Anemia	Abnormal Bleeding		Abnormal Bruising	
Bleeding Disorder				
Blood Transfusion	Other: _____			
Respiratory				
Asthma	Wheezing	Chest Congestion	Oxygen Use	
Bronchitis	Shortness of Breath			
Emphysema	Cough:	Productive	Nonproductive	
Pneumonia				
Tuberculosis	Other: _____			

Medical History	Current Symptoms
<i>Please circle all that apply</i>	<i>Please circle all that apply</i>
Gastrointestinal	
Constipation	Diarrhea Ulcers Bowel Incontinence
Gallbladder Disease	Vomiting Nausea Blood in Stool (Black or Tarry)
GERD (Heartburn)	Decreased Appetite Pain: Abdominal Rectal
Liver Disease	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	Hot Flashes / Night Sweats Pain/Bleeding During Sex
Past Pregnancies (#____)	Currently Pregnant Vaginal Discharge/Itching
Past Deliveries (#____)	Significant Pain/Cramps with Menses
	Breast: Discharge Lumps Pain Nipple Inversion
	Other: _____
Mens' Health:	
	Erectile Concerns Testicle Lumps/Swelling
	Other: _____
Musculoskeletal	
Arthritis	Joint Swelling
Fractures	Pain: Back Joint Limb Muscle Neck Bone
Osteoporosis	Other: _____
Skin	
	Hives Itchy Skin <i>Surgical Incision</i>
	Masses Rashes Skin Changes
	Other: _____
Psychiatric	
Anxiety or Panic Disorder	
Depression	
PTSD (Post-Traumatic Stress Disorder)	
	Other: _____

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?		
<i>please circle below</i>		
Support Groups	Lodging	Home Health
Transportation	Insurance	Other: _____

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 Phone: 904-880-5522
Jacksonville, FL 32223 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

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

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