PATIENT INFORMATION

NAME: ____ ____________________
(FIRST) (MIDDLE) (LAST)

DATE OF BIRTH: ______________ SOCIAL SECURITY #: ________________

ADDRESS: ______________________________ CITY: ____________ STATE: _____ ZIP__________

HOME PHONE: (____)____________ CELL PHONE: (____)____________ WORK PHONE: (____)____________

MARITAL STATUS: ☐ MARRIED ☐SINGLE ☐ WIDOWED ☐DIVORCED

EMERGENCY CONTACT: ____________________________________ PHONE :(____) ______________

RACE: __________________ PRIMARY LANGUAGE: ENGLISH SPANISH OTHER______________

SEX: ☐ MALE ☐ FEMALE ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO

EMAIL ADDRESS: ____________________________________

REFERRED BY: __________________________ PRIMARY CARE PHYSICIAN: ________________________

SPECIALIST PHYSICIAN(S): __________________ __________________ __________________

INSURANCE SUBSCRIBER INFORMATION

PRIMARY INS. NAME: ____________________	SECONDARY INS. NAME: ____________________
NAME OF SUBSCRIBER: ____________________	NAME OF SUBSRCIBER: ____________________
SUBSCRIBER'S DATE OF BIRTH: ______________	SUBSCRIBER'S DATE OF BIRTH: ______________

I hereby authorize my insurance benefits to be paid directly to First Dayton Radiation Oncology. I also recognize that I am responsible to pay for non-covered services or in the event I do not have insurance coverage I am responsible for all charges for services rendered while I am uninsured. I hereby authorize the release of pertinent medical information to the above named insurance carrier(s).

Signature: ____ Date: ____________________

ACKNOWLEDGEMENT OF NOTICES

A copy of the First Dayton Cancer Care Notice of Privacy Practices and Notice of Nondiscrimination Practices can be found on our web site, www.firstdaytoncyberknife.com under For Patients / Patient Forms. A written copy is also available by request at the front desk.

PRIVACY PRACTICES:

I acknowledge that I have been offered or received a copy of First Dayton Cancer Care Notice of Privacy Practices.

____________________ **(Initial)**

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

____________________ **(Initial)**

I authorize my healthcare provider to access my pharmacy data electronically and to download a historic list of all medications prescribed by any provider.

____________________ **(Initial)**

PRIVACY INSTRUCTIONS:

Yes ☐ **No** ☐ May we leave detailed messages on your answering machine or voice mail (e/g/ test results, billing information, etc.)? **If yes, please provide your preferred phone number:** (____)____________________

Yes ☐ **No** ☐ May we discuss details regarding your care, test results, billing information, or appointment information with someone else, other than you? If yes, please list the name and relationship of each individual below.

	NAME	RELATIONSHIP	PHONE
1			
2			
3			

You may revoke or update this information at any time in writing.

You may refuse to sign this acknowledgment and authorization. In refusing we may not be allowed to process your insurance claims. Reason for refusal (may be completed by patient or staff): ______________________________

____

NONDISCRIMINATION PRACTICES:

First Dayton Cancer Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. If you require information regarding your medical care in a language other than English, it will be provided to you at your request.

I acknowledge that I have been offered or received a copy of First Dayton Cancer Care's Notice of Nondiscrimination Practices.

____________________ **(Initial)**

Signature of Patient or Representative: ______________________________ Date: ______________

Print Name: ______________________________

Relationship of Representative/Authority to act on behalf of patient: ______________________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This release grants First Dayton Cancer Care permission to obtain and /or release my medical records. I understand that I might be releasing to the person / organization identified below as well as the medical registries of OCISS (Ohio Cancer Incidence Surveillance System), OARRS (Ohio Automated Rx Reporting System) information which is specifically protected under provisions of state and / or federal law. I understand I may revoke this authorization at any time except to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. To revoke this authorization, I must advise First Dayton Cancer Care in writing. I understand this release of medical records will remain in effect from the date signed until I revoke this authorization in writing.

PATIENT / PATIENT REPRESENTATIVE PLEASE ONLY COMPLETE THIS BOX

PATIENT NAME: ______________________________ DATE of BIRTH: ____________________

PATIENT SIGNATURE: ______________________________ DATE: ____________

SIGNATURE OF PARENT/LEGAL GUARDIAN: ______________________________ DATE: ____________

FOR OFFICE USE ONLY
PLEASE DO NOT FILL ANYTHING OUT BELOW THIS LINE

Information is to be released to:

□ First Dayton Cancer Care
2632 Woodman Center Ct.
Kettering, Ohio 45402
Phone: (937) 293-2273
Fax: (937) 293-6573

OR

____
____
____
____
____

And shall include information from the above-named facility's records, including photocopies, relating to the patient's identity, diagnosis, prognosis, and / or treatment including:

_____ All records pertinent to continued care
_____ History & Physical
_____ Radiation Summary
_____ Imaging Reports
_____Pathology / OP Notes
_____ Physician Notes
_____ Lab Reports
_____ Other (specify):

____

Records are to be: □ Faxed □ Mailed □ Held for Pick Up

FIRST DAYTON CANCER CARE

Name ______________________ R.T. No. ____________ Date ____________

MEDICAL HISTORY (Check only those that apply)

TEETH
- ☐ Dentures ☐ up ☐ low
- Last dental visit : ____________

HEARING
- ☐ Hearing Aid ☐ R ☐ L
- ☐ Deaf

VISION
- ☐ Glasses
- ☐ Contacts
- ☐ Artificial Eye
- ☐ Blind
- ☐ Cataracts

IMPLANTED DEVICES
- ☐ Pacemaker
- ☐ Venous access
- ☐ Cardioverter/ Defibrillator
- ☐ Other ____________

Have you ever had a problem with: (Check only those that apply)

☐ Bowel/Rectal bleeding	☐ HIV/Venereal Disease	☐ Breathing	☐ Neck/Jaws
☐ Stomach/Hiatal hernia	☐ Nerves	☐ Stroke	☐ Walking
☐ Kidney/Bladder/Prostate	☐ Heart/Murmur	☐ Hepatitis/Liver	☐ Arthritis
☐ High Blood Pressure	☐ Knees/Hips	☐ Tuberculosis	☐ Gynocological Problem
☐ Diabetes	☐ Seizures	☐ Back	☐ Depression
☐ Low Blood Sugar	☐ Thyroid	☐ Pneumonia/Emphysema	☐ Other

Comments: ______________________

PSYCHOSOCIAL

Are you troubled by: Worry about your family? ☐ Always ☐ Sometimes
Feeling sad? ☐ Always ☐ Sometimes

Have you discussed your sickness and treatments with your family or friends? ☐ Yes ☐ No
If yes, was it helpful? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Number of Pregnancies ____________ Number of Children ____________

Who lives at home with you? ☐ Spouse ☐ Children ☐ Parents ☐ Other ☐ Live alone

Who helps you at home? ☐ Spouse ☐ Children ☐ Parents ☐ Other ☐ Live alone

Does this person have health problems? ☐ Yes ☐ No

What helps you when you are upset (your coping mechanisim)? ______________________

____

Do you need help with rides getting to and from the doctor and/or hospital? ☐ Yes ☐ No

Are you receiving agency support? ☐ None ☐ Visiting Nurse ☐ Meals on Wheels ☐ Physical Therapy ☐ Other ____________

COMFORT LEVEL

Do you have pain? ☐ Yes ☐ No If yes, where? ____________

How long does the pain last? ____________

What gives you relief from the pain? ____________

Does your pain prevent you from normal activities? ☐Yes ☐ No

If yes, please explain ____________

PREVIOUS CHEMOTHERAPY ☐ Yes ☐ No

If yes, when & where? ____________________

PREVIOUS RADIATION ☐ Yes ☐ No

If yes, when & where? ____________________

OPERATIONS

Type	Date	Type	Date

Did you have any bleeding problems? ☐ Yes ☐ No

If yes, please explain ____________________

____

PREVIOUS PROBLEMS WITH ANESTHESIA ☐ Yes ☐ No

If yes, please explain ____________________

____

MEDICATIONS

Name	Dose	Times/Day

ADVANCED DIRECTIVE / LIVING WILL / DNR

Do you currently have any of the above: ☐ Yes ☐ No

** Please bring us a copy if you answered yes.

ALLERGIES to medications: ☐ Penicillin ☐ Sulfa ☐ Other ____________________

to food: ____________________

HABITS

Smoking ☐ Yes ☐ No (If checed No but smoked previously, please complete)

Amount ____________ No. Years ____________

Alcohol ☐ Yes ☐ No

Amount ____________ No. Years ____________

Exercise ☐ Yes ☐ No If yes, type of activity & amount

____

FAMILY HISTORY

	Relationship	Type
Cancer		
Other Diseases/Illnesses		