

# Southeast Cancer Network, Inc.

## NEW PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Last First M.I. Home Telephone*

Home Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
*Street Street*  
\_\_\_\_\_  
*City State Zip City State Zip*

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ M F SS# \_\_\_\_\_ Married Single Divorced Widowed Other  
*Sex Check Marital Status*

Employer: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Name Telephone*  
\_\_\_\_\_  
*Address Occupation*

Responsible Party: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Name Relationship Telephone*

Emergency Contact:  
Spouse/Next of Kin: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Name Relationship Telephone*

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Telephone*

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Telephone*

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy: \_\_\_\_\_

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Southeast Cancer Network, Inc. (SCN), I also authorize agents of any hospital, treatment center or previous physicians to furnish SCN copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within SCN.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to SCN. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to SCN.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administrations, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfactions surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with SCN.
5. Personal Valuables: I acknowledge that SCN shall not be liable for the loss or damages to any personal property.
6. Consent for photograph: I, the undersigned, give SCN, its physicians and staff, permission to make photographs of me for placement into my clinical record.
7. Patient's bill of rights and responsibilities: See back of form.

**This Agreement/Consent will remain in effect unless revoked by me in writing.**

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Today's Date: \_\_\_\_\_

**MR:** \_\_\_\_\_  
For Official use only

### HISTORY & PHYSICAL

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Divorced  Married  Widowed  
Number in Household: \_\_\_\_\_  
Education (Highest grade/degree): \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Medical History: (past diseases or illnesses) \_\_\_\_\_

Surgeries:			Medications:		
Type	Date	Doctor	Name	Dosage	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Allergies: (List Drug and Describe Reaction)**  
\_\_\_\_\_  
\_\_\_\_\_

Habits:	YES	NO	TYPE	HOW OFTEN	# YEARS
Alcohol	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Other Substance Abuse	_____	_____	_____	_____	_____

#### Medical History:

Condition	Self	Father	Mother	Brother	Sister
Heart Attack	_____	_____	_____	_____	_____
Hypertension/Stroke	_____	_____	_____	_____	_____
Cancer*	_____	_____	_____	_____	_____
Blood/Bleeding Problem	_____	_____	_____	_____	_____
Mental Illness/Suicide	_____	_____	_____	_____	_____

\*Briefly Describe: \_\_\_\_\_

#### Review of Conditions: (Mark all that apply)

- |                                      |                                       |   |  |                                     |
|--------------------------------------|---------------------------------------|---|--|-------------------------------------|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Cough/Dry        | <input type="checkbox"/> Fever               | <input type="checkbox"/> Skin Rash  |
| <input type="checkbox"/> Weakness    | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Bleeding         | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizziness  |
| <input type="checkbox"/> Fainting    | <input type="checkbox"/> Cough/Wet    | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Nausea      | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Blurred Vision      |                                     |

#### Females Only:

**Menstrual Cycle:**  Regular  Irregular  Heavy  Light  Cramps  
 Spotting between cycles  Passing clots

Menopause:  Yes  No If yes, Date: \_\_\_\_\_ Mammogram:  Yes  No If yes, Date: \_\_\_\_\_

Location of Mammogram: \_\_\_\_\_

Date-Last Pap Smear: \_\_\_\_\_ Breast Exam: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_