DR. WODAJO NEW PATIENT FORM

PATIENT INFO: PLEASE PRINT

Last Name _____ First Name _____ M.I. _____ Today's Date _____

DOB: _____ Height: _____ Weight: _____ Sex: M ☐ F ☐

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Patient Address (street): _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Preferred method of contact (circle one) - Home Phone Mobile Phone Work Phone E-mail

Emergency Contact Name: _____ Relationship: _____

Emergency/Phone: _____ Emergency/Alternate Phone: _____

Employer Name: _____ Employer Telephone: _____

Employer Address: _____ Occupation: _____

Full time ☐ Part Time ☐ Retired ☐ Unemployed ☐

REFERRING DOCTORS:

Referring Doctor First Name: _____ Last Name: _____

Orthopedic Doctor First Name: _____ Last Name: _____

Radiation Oncologist First Name: _____ Last Name: _____

Medical Oncologist First Name: _____ Last Name: _____

Primary Care or Pediatrician First Name: _____ Last Name: _____

REASON FOR VISIT (please provide details with dates):

_____

_____

_____

IMAGING STUDIES: Please provide name and location where you had your imaging done (you must bring the disk to your appointment. You will be rescheduled if you do not have your disk with you).

X-Ray: _____

CT Scan: _____

MRI: _____

Bone Scan: _____

PET Scan: _____

Ultrasound: _____

Other: _____

DR. WODAJO NEW PATIENT FORM

SURGICAL HISTORY: Please list the following. If you need additional space, it is provided on the last page.

Surgeries (with dates):

ALLERGIES ADVERSE DRUG REACTIONS (types of reactions, be specific)

MEDICATIONS: Please list all medications, including *prescription, non-prescription, and other (including herbal)* that you are currently taking. Please include *dosage* and *frequency* taken.

Medication	Dosage	Frequency

PHARMACY*:* Please list name and address of your preferred local pharmacy:

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ **State:** _____ **Zip Code:** _____

DR. WODAJO NEW PATIENT FORM

MEDICAL CONDITIONS

Check all that Apply

Psychological

- ☐ ADD/ADHD
- ☐ Anxiety/Depression
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Eating Disorder
- ☐ OCD
- ☐ Post-Traumatic Stress Syndrome

Communicable/Infectious Disease

- ☐ AIDS/HIV
- ☐ Herpes Simplex

Autoimmune Disorders

- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Multiple Sclerosis

Pulmonary/Respiratory

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Lung Disease
- ☐ Sleep Apnea

Genitourinary

- ☐ Benign Prostatic
- ☐ Hypertrophy (BPH)

Hematological

- ☐ Anemia
- ☐ Deep Venous Thrombosis
- ☐ Pulmonary Embolism

Chronic Disease

- ☐ Arthritis
- ☐ Fibromyalgia Osteopenia/Osteoporosis
- ☐ Past History of Cancer

If Yes, Type of Cancer: _____

Gastro/Intestinal

- ☐ Crohn's/Ulcerative
- ☐ Colitis
- ☐ Diverticulitis
- ☐ GERD/Hiatal Hernia
- ☐ Hepatitis A/B/C
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Reflux
- ☐ Ulcers

Cardiovascular

- ☐ Collagen Vascular Disease
- ☐ Coronary Artery Disease/MI or Angina
- ☐ Heart Arrhythmia
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Stroke

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other Endocrinological Disorder

Gynecological

- ☐ Dysfunctional Uterine
- ☐ Bleeding
- ☐ Endometriosis
- ☐ Polycystic Ovarian Disease

Nephrology

- ☐ Kidney Disease
- ☐ Kidney Stones

Neurological

- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Parkinson's
- ☐ Seizures

Skin

- ☐ Hives
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other

Other

- ☐ Gout
- ☐ Restless Leg Syndrome

DR. WODAJO NEW PATIENT FORM

SYMPTOMS: Please list any symptoms you may have in the past 6 months in the categories below.

Constitutional

- ☐ Weight Loss
- ☐ Poor Energy Level
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

Eyes

- ☐ Double Vision
- ☐ Vision Loss
- ☐ Flashing Lights

ENT/Mouth

- ☐ Ringing in Ears
- ☐ Oral Ulcers
- ☐ Nasal Drip
- ☐ Hearing Loss
- ☐ Bleeding Gums
- ☐ Mouth Pain
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Sinus Pain

Cardiovascular

- ☐ Chest Pain or Pressure upon Exertion

If yes, explain: _____

_____

- ☐ Arm/Leg Swelling
- ☐ Palpitations
- ☐ Calf Discomfort
- ☐ Fainting Spells
- ☐ Arm Swelling

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing Blood
- ☐ Pain w/Breathing

Breast

- ☐ Mass
- ☐ Pain
- ☐ Nipple Discharge
- ☐ Change in Size
- ☐ Change in Shape

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Lack of Concentration

Gastrointestinal

- ☐ Vomiting
- ☐ Jaundice
- ☐ Abdominal Pain
- ☐ Maroon/Black Stool
- ☐ Constipation
- ☐ Abdominal Cramping
- ☐ Diarrhea
- ☐ Vomiting Blood
- ☐ Change in Swallowing
- ☐ Nausea

Urinary

- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Increased Frequency
- ☐ Loss of Control
- ☐ Impotence

Gynecological

- ☐ Vaginal Discharge
- ☐ Pelvic Pain
- ☐ Vaginal Dryness
- ☐ Unexplained or
- ☐ Heavy Bleeding

If yes, explain: _____

_____

Musculoskeletal

- ☐ Muscle Pain
- ☐ Spine Tenderness
- ☐ Swollen Joints
- ☐ Joint Redness
- ☐ Bone Pain

Endocrine

- ☐ Excessive Urine
- ☐ Excessive Thirst
- ☐ Hot Flashes
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Hematological

- ☐ Nose Bleeds
- ☐ Bleeding Gums
- ☐ Purple Spots on Hands
- ☐ Bruising

Neurological

- ☐ Confusion
- ☐ Seizures
- ☐ Fainting Spells
- ☐ Tremors
- ☐ Speech Change
- ☐ Headache
- ☐ Hiccups
- ☐ Abnormal Gait Weakness
  - ☐ Upper Extremity
  - ☐ Left Side
  - ☐ Lower Extremity
  - ☐ Right Side
- ☐ Sensory Change
- ☐ Abnormal Numbness/Tingling

If yes, explain: _____

_____

Lymphatic

- ☐ Enlarged Lymph Nodes
- ☐ Swelling in Arms

Skin

- ☐ Rash
- ☐ Nodules
- ☐ Itchiness
- ☐ Lesions

If yes, explain: _____

_____

DR. WODAJO NEW PATIENT FORM

HEALTH HISTORY AND PREVENTATIVE HEALTH MAINTENANCE

Please provide dates for each answer or write "none".

Mammogram: _____ Bone Density Scan: _____

Colonoscopy: _____ Pneumonia Vaccine: _____

Have you ever had a blood transfusion? ☐ **Y** ☐ **N,** If yes, when?_____

Have you had a flu vaccine this flu season?: ☐ Y ☐ N If so, when? _____

Have you had your COVID19 vaccination? ☐ Y ☐ N

Have you received any COVID boosters? If so, how many _____

Sex (assigned at birth, check one) ☐ Male ☐ Female

Gender Identity_____ Sexual Orientation_____

SOCIAL & ENVIRONMENTAL REVIEW (If Yes, please fill out type, quantity, how often, etc...)

Do you drink alcoholic beverages: ☐ Y ☐ N How many drinks per week/month: _____

Have you ever smoked cigarettes? ☐ Y ☐ N Are you currently smoking? ☐ Y ☐ N

Packs per day? _____ How many years? When did you quit? _____

Do you use recreational drugs? ☐ Y ☐ N How often? _____ How much?_____

What type? _____ If quit, when?_____

Married ☐ Single ☐ Divorced ☐ Widowed ☐

With whom do you live? _____ Occupation? _____

Race (optional):_____ **Preferred Language (optional):**_____

Ethnicity (circle or leave blank)- Hispanic/Latino or Non Hispanic/Latino

FAMILY HISTORY: Please list any illnesses in your family, including all cancers (e.g., breast cancer, colon cancer, ovarian cancer, etc.) and blood disorders (e.g., anemia, blood clotting disorders, etc.).

Relationship	Illness, cancer or blood disorder	Age of diagnosis	Are they deceased?

DR. WODAJO NEW PATIENT FORM

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above. Please mark what section they correspond to.

ADVANCE DIRECTIVE

Do you have an Advance Directive, also known as a Living Will? ☐ Y ☐ N

If yes, please provide us with a copy for your medical record when you are next in our offices.

If no, please consider completing an Advance Directive, as recommended for all adults regardless of health status.

If you were ever unable to speak for yourself, who would the doctors speak to on your behalf?

Name: _____ **Phone:** _____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION IN THE FORM OF PHOTOGRAPH, VIDEOTAPE, AUDIOTAPE, OR OTHER MEDIA

The undersigned hereby authorizes Virginia Cancer Specialists and Felasfa Wodajo, MD to record me using photography, videotape, audiotape, and/or other media. This recording is for the purpose of clinical documentation and research. All attempts will be made to conceal any identifying features, such as my face, but I understand that it cannot be guaranteed.

The foregoing is subject to such limitations as indicated below:

I understand that I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to Virginia Cancer Specialists. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Virginia Cancer Specialists is not responsible for any redisclosure of the information provided.

Signature of Patient (or Legal Representative*)_____

Patient Printed First Name_____ **Last Name:**_____

Date: _____

***Relationship/Authority of Legal Representative:** _____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Patient Name: _____ _____
Last First M.I. Today's Date

( ) _____ ( ) _____
Home Telephone Cell phone

Home Address: _____ Mailing Address: _____

_____ _____
City State Zip City State Zip

DOB: _____ Age _____ ☐ M ☐ F SS# _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Sex

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: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ 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 Virginia Cancer Specialists, P.C. I also authorize agents of any hospital, treatment center or previous physician to furnish Virginia Cancer Specialists, P.C. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report 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 Virginia Cancer Specialists, P.C.
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 Virginia Cancer Specialists, P.C. 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 Virginia Cancer Specialists, P.C.
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 payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, 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 satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

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/Time AM or PM (circle one)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (circle one)

PHYSICIAN _____
ACCT NBR _____ LOC _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Virginia Cancer Specialists, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Virginia Cancer Specialists.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Virginia Cancer Specialists Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained and employee signature:

_____

_____

_____

Virginia Cancer Specialists

PERMISSION FOR VERBAL COMMUNICATIONS

To protect the patient's privacy and to ensure that our clinic staff and physicians know whom they have permission to communicate with regarding the patient's protected health information, it is helpful for patients to have a Permission for Verbal Communications form on file at Virginia Cancer Specialists.

_____

Patient's Name

I permit Virginia Cancer Specialists to discuss health information with the following individuals involved in my medical care or payment of my care:

List individuals and state the person's relationship to the patient.

Name	Phone Number	Relationship
1.		
2.		
3.		

****

This authorization is limited to discussions regarding the following medical condition(s):

_____

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

****

This authorization is limited to the following timeframe from

_____ (date) to _____ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

_____

Patient's Signature **Date**

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____

Name of Personal Representative **Relationship to Patient**

_____

Witness **Date**

Virginia Cancer Specialists

PATIENT CONSENT FORM - 3rd PARTY API

A new option for you to view your health information

What is a 3rd Party API?

An application you can access using a computer, phone or tablet to view the health information in your chart. Depending on the type of app, you will be able to view information such as diagnoses, lab results and medication lists. Apps may offer different features, so you can pick what best meets your needs.

Why?

New Medicare requirement to give patients the option to view their information using a 3rd Party Application. This is in addition to our patient portal, My Care Plus.

How?

- Complete consent for 3rd party API.
- Request a registration access code from our office. *(**Codes expire after 7 days.)*
- Access the iKnowMed API Portal website to enter your code and create an account. https://apiaccess.mckesson.com
- You will need to use Chrome to access the iKnowMed API Portal.
- Applications that meet the iKnowMed security and technical requirements will be listed.
- You may select any applications from the list, and depending on the application, access them from a computer, phone or tablet.

Registration is open for patients as of 9/3/18, as 3rd party applications become available they will be added the website.

By signing below, I hereby consent to use of the 3rd party API technology. At any point in time, it is my right to decline the use of 3rd party API.

_____ _____ _____

Patient's Name (PRINT) Patient's DOB IKM ID

_____ _____

Patient's Signature Date

_____ _____

Signature of Practice Staff Date

[Confirming user's identity and authority]

Staff: Complete consent process in IKM then scan document.