

**NORTHEAST GEORGIA CANCER CARE  
PATIENT INFORMATION FORM**

**Physician:**    MV             GW             NM             JT             JS             PN  
                   NS             RT             GS

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex:    Female    Male

Race:    African American or Black    American Indian    Asian    Hispanic    White    Other \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Retired:    Yes    No                      Former Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

**Nearest Relative** (Someone we can contact in case of emergency):

Relation to Patient:    Spouse    Parent    Son    Daughter    Friend    Other \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

- .....
1. I authorize the physicians of NEGACC to treat the above-named patient. Treatment may include drawing blood.
  2. Your insurance is filed as a courtesy to you. All services not paid within 30 days by your insurance company will become your responsibility. I further understand I must set up a payment plan and pay the account balance in full in 90 days.
  3. All co-pays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit.
  4. As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. We always advise patients to know the benefits/coverage of your insurance. As a courtesy, Northeast Georgia Cancer Care will obtain pre-certification for outpatient procedures. **PRECERTIFICATION DOES NOT GUARANTEE PAYMENT.**
  5. **Assignment of Benefits:** I request that payment of authorized benefits be made on my behalf to Northeast Georgia Cancer Care, LLC.
- .....

**Office Use Only:**            Masterfile Entered: \_\_\_\_\_            Account Number: \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

I request that payment of authorized Medicare, Medigap or other insurance benefits be made on my behalf to Northeast Georgia Cancer Care, LLC for services provided.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, my Medigap insurer or any other insurance company about which I have provided billing information, any information needed to determine benefits payable.

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

.....

**INSURANCE INFORMATION**

(We will need a copy of your insurance cards, including Rx card. Please list Medicare or Medicaid if you have either.)

**Original Insurance**       **New Insurance**

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

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name (If different from patient): \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

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

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name (If different from patient): \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

**Do you have prescription coverage?**  Yes  No    If yes, through what program? \_\_\_\_\_

**Are you a resident of a skilled nursing facility?**  Yes  No

Name of Facility: \_\_\_\_\_

Facility Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

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**ADDITIONAL INFORMATION NEEDED FOR PROCESSING OF INSURANCE:**

Are you still working?  Yes  No

Do you have employer group health coverage?  Yes  No      Number of employees? \_\_\_\_\_

Is your spouse still working?  Yes  No      Retirement Date? \_\_\_\_\_

Are you covered through your spouse's insurance?  Yes  No      Number of employees? \_\_\_\_\_

Do you have a cancer or individual policy you wish us to file for you?  Yes  No

Does it allow for assignment of benefits?  Yes  No

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

### Review of Systems/Medical History

Do you currently experience any problems related to the following systems? Check the appropriate box.

<p><b><u>General Symptoms:</u></b></p> <p>Fatigue <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Weight Loss <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Fever, Chills <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Night Sweats <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Loss of Appetite <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><b><u>Cardiac:</u></b></p> <p>Heart Failure/Cardiovascular Disease <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Palpitations <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Pace Maker <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Heart Attack <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>High Blood Pressure (Hypertension) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b><u>Neurological/HEENT:</u></b></p> <p>Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Blurry or Double Vision <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Dizziness <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Passing Out (Syncope) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hearing Loss <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Weakness <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Difficulty Speaking or Walking <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Problems Swallowing <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Strokes <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><b><u>Respiratory:</u></b></p> <p>Shortness of Breath <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Frequent Cough <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Wheezing <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Lung Disease <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Coughing Blood <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Pneumonia <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b><u>Psychiatric:</u></b></p> <p>Depression <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Insomnia <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Anxiety <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Psychiatric Illness <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><b><u>Gastrointestinal:</u></b></p> <p>Nausea or Vomiting <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Mouth Sores <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Abdominal Pain <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Constipation <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Bloody Bowel Movements <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Liver Disease/Problems <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Gall Bladder Disease <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b><u>Genitourinary:</u></b></p> <p>Prostate Disorder <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Blood in Urine <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Difficulty or Pain on Urination <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Kidney Disease <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><b><u>Hematologic/Lymphatic:</u></b></p> <p>Bruising <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Bleeding Problems <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Low Blood Count <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Swollen Glands <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Lymph Nodes (Lumps or Bumps) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Blood Clots <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b><u>Musculoskeletal:</u></b></p> <p>Swelling Feet/Legs <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Pain/Swelling Joints <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Back Pain <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Rheumatoid Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Osteoarthritis <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><b><u>GYN:</u></b></p> <p>Are you pregnant or is there any chance that you could be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Vaginal Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b><u>Skin/Integumentary:</u></b></p> <p>Rash <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Skin Disorders <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p><b><u>Endocrine:</u></b></p> <p>Thyroid Disease/problems <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Date: \_\_\_\_\_

*Please list:*

<b><u>ALLERGIES TO MEDICATIONS</u></b>	<b>RESPONSE</b> (ex. rash, shortness of breath, nausea/ vomiting)
<b>Other (ex. tape, iodine, latex):</b>	

*Previous surgeries:*

<b>Date (year)</b>	<b>Type of surgery</b>

*Other hospitalizations:*

<b>Date (year)</b>	<b>Reason for hospitalization</b>

*Please list any medications you are currently taking including vitamins, herbal supplements and contraceptives:*


*Pharmacy you regularly use:*

<b>Name</b>	<b>City</b>	<b>Phone number</b>

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

### Family Medical History:

	Type of cancer	Blood disorder	Other (ex. diabetes, heart disease, tuberculosis, etc.)
<b>Mother</b>			
<b>Father</b>			
<b>Brother</b>			
<b>Sister</b>			
<b>Grandparents</b>			

### Social History:

Occupation: \_\_\_\_\_

Have you ever served in the military?  Yes  No

Do you smoke?  Yes  No

Did you ever smoke?  Yes  No If yes, how long? \_\_\_\_\_

Do you drink alcohol?  Regularly  Occasionally  Never

Are you currently married?  Yes  No

Number of children: \_\_\_\_\_

Number of brothers: \_\_\_\_\_

Number of sisters: \_\_\_\_\_

*Please list any doctors you are currently seeing:*

	Name	City	Phone
<b>Primary Care Physician</b>			
<b>Surgeon</b>			
<b>Medical Oncologist</b>			
<b>Radiation Oncologist</b>			
<b>Other</b>			