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Name:_____ DOB: _____ Age: _____

Primary Physician: _____
Other Physician: _____
Pharmacy of Choice: _____Location: _____
Marital Status: _____ Language: _____ Ethnicity_____ Race: _____
Advance directive☐ DNR ☐ Power of attorney☐ Living Will☐

Social History: Occupation: _____ Retired: Yes☐ No☐
Alcohol use: Yes ☐ No☐ Drinks per day _____ quit: Yes☐ No☐
Tobacco use: Yes☐ Amount _____ quit: Yes☐ # Years smoked ____ Never smoked ☐
Exercise Routine Yes ☐ _____No☐

Past Medical History (check any that apply):

☐Diabetes	☐Heart Disease	☐Heart Attack (date)_____	☐Arthritis
☐High Blood Pressure	☐Thyroid Problems	☐Kidney Disease	Other:
☐Emphysema	☐Liver Disease	☐High Cholesterol	_____
☐Nerve problems	☐Stroke	☐Bowel Problems/Colitis	_____
☐Acid Reflux	☐Asthma	☐Chronic Bronchits	_____

Past Surgical History:

☐Gallbladder	☐Shoulder Sx	☐Cataract Sx	☐Hernia	☐Appendix
☐Back Surgery	☐Hysterectomy	☐Knee Sx	☐Breast Sx	☐_____
☐Lung Sx	☐Hip Sx	☐Coronary artery Sx	☐Bowel/Colon Sx	_____

Previous Radiation: Yes☐ No☐ Where?_____ When? _____
Chemotherapy: Yes☐ No☐ Last Given_____
Allergies to medication/Iodine dye/ Latex _____

GYN History (If Applicable)
Last menstrual Period _____ Hormone Use _____
Number of pregnancies_____ Number of Children _____

System Review (check all that apply)

☐Headache	☐Mouth sores	☐abdominal pain	☐Blood in urine	☐Loss of strength
☐Confusion	☐Trouble swallowing	☐diarrhea	☐Painful Urination	☐loss of balance
☐Visual Changes	☐Heartburn	☐constipation	☐Frequent urination	☐Coordination Loss
☐Dizziness	☐chest pain	☐Blood in stool	☐Bone Pain	☐ loss of appetite
☐Double Vision	☐short of breath	☐Tarry stool	☐Joint pain	☐Weight loss
☐Falling	☐Cough	☐hemorrhoids	☐Muscle pain	☐Nausea
☐ Fever	☐Chills/Night sweats		★How severe is your pain on a scale of 1-10? __	

☐Fatigue. On a scale of 1-10, how fatigued are you? _____
☐Other symptoms_____ ☐ SKIN LESIONS THAT DO NOT HEAL

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FAMILY MEDICAL HISTORY (CHECK ANY THAT APPLY):

☐ NOT APPLICABLE/NOT AVAILABLE, or

Relative	Current age	Age at death	Health Problems (if cancer, please specify type)
Mother			
Father			
Grandparents			
Siblings			
Aunts/Uncles			
Other			

MEDICATION LIST (Include supplements and vitamins, over the counter, ear/eye drops, creams)

EXPOSURE: Asbestos ☐ Chemicals☐ Dust☐ Other:_____ None ☐

DR: _____

APT DATE: _____

APT TIME: _____

PLEASE CHECK IN BY: _____

PT LAST NAME: _____

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NOTICE OF PRIVACY PRACTICES

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information; and required by the Health Information Privacy Portability Act of 1996 (HIPPA) we hereby inform you how your information may be used and disclosed, and how you can obtain copies of your records. We are obligated by law to maintain the highest level of confidentiality about you and your health information and will only share specific information with your written consent as follows.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN CIRCUMSTANCES

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and/or similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we only contact you at home, rather than at your work place. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to certain individuals involved in your care, or the payment of your care, such as family members and friends. We are not required to agree to your request; however, we are bound by our mutual agreement except when required by law, in emergencies, or when the information is necessary to treat you.

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3. You have the right to inspect and obtain copies of your health information which may be used to make decisions about you, including medical and billing records; but not including psychotherapy notes. You must submit your request in writing to the Practice Administrator, Cochise Oncology, 5151 E. Hwy 90, Sierra Vista, AZ 85635.
4. You may ask us to amend your health information if you believe it to be incorrect or incomplete, as long as the information is kept by or for our practice as an amendment. Your request must be made in writing as directed above.
5. You are entitled to receive a copy of this Notice of Privacy Practices at any time by contacting our Front Desk Receptionist.
6. You have the right to file a complaint if you feel your privacy rights have been violated. Your written complaint can be filed with our Practice Administrator, as directed above, or with the Dept. of Health and Human Resources. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies please contact our Practice Administrator.

I hereby acknowledge that I have been presented with a copy of Cochise Oncology's Notice of Privacy Practices.

I hereby acknowledge that I have the right to request a copy of Cochise Oncology's Notice of Privacy Practice at any time.

PRINTED NAME OF PATIENT: _____

SIGNATURE: _____ DATE: _____

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Signature on File

Patients Name: _____ Patient SSN: _____

Assignment of Benefits

I hereby authorize payment of medical benefits to Cochise Oncology, LLC for professional services rendered.

Release of Information

I hereby authorize the release of any medical information necessary to the insurer for determining what benefits may be payable.

Financial Responsibility

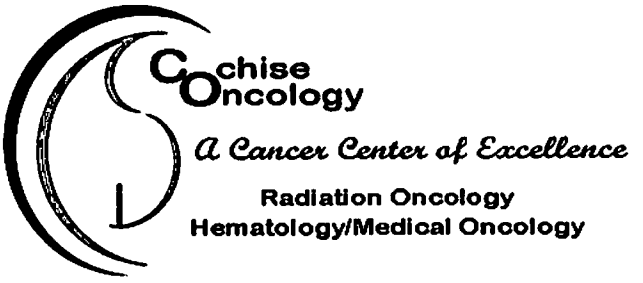
I understand that I am responsible for any fees or amounts not covered by my insurance company. I also understand that if my insurance denies payment for my claim, I will pay the outstanding amount immediately.

If my insurance company fails to pay for my claim within 60 days, I understand that I will be responsible for the payment in full of the remaining balance. If I do not pay for the amount that is due, I understand that I will be responsible for any fees associated in collecting the amount due including but not limited to attorney, collection or court costs.

If the Patient is not the Primary Insured on the Insurance:

Primary Insured's Name: _____
Primary's SSN: _____ Primary's DOB: _____
Primary Insured's Address (if different from Patient):
_____

Signature: _____ Date: _____



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AUTHORIZATION FOR THE RELEASE OF INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I authorize Cochise Oncology to obtain my medical records from the following health care practitioners:

Primary Care Doctor: _____

Any Other Doctors You See: _____

_____

_____

_____

Please provide the following information from my medical records:

Duplicate copy of my medical records
Pathology results
Radiology reports
Other: _____

The purpose of this request is for:

Further medical care
Insurance
Other: _____

I further authorize Cochise Oncology to obtain my past medication history for continuity of care.

I understand that this authorization can be terminated with my written request.
A photocopy of this authorization is fully acceptable.

PATIENT SIGNATURE: _____ DATE: _____

COCHISE ONCOLOGY STAFF WITNESS: _____

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CONTACT CONSENT

May our office staff leave any telephone messages at the following phone numbers?

Home: _____Yes _____No PHONE#:_____

Cell: _____Yes _____No PHONE#:_____

Work: _____Yes _____No PHONE#:_____

Other: _____Yes _____No PHONE#:_____

Email Address: _____

Please list the names of any individuals that our office staff has permission from you to speak with or contact in the event that we are unable to reach you.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

_____

Patient Signature Date

_____

Cochise Oncology Staff Witness Date

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Use of Photo Film Voice Authorization

Please choose **ONE**

I hereby release to **Cochise Oncology** rights to my image, likeness and sound of my voice for marketing and social media purposes. I understand that my picture, voice, or images of me on film may appear on marketing materials and/or media sources (including but not limited to: websites, radio, print ads, commercials and newsletters)

I acknowledge this release is firm and final and understand that Cochise Oncology may proceed in reliance thereon.

Patient Name

Patient Signature Date

I hereby ***DO NOT*** release rights my image, likeness and sound of my voice to **Cochise Oncology** for marketing and social media purposes. I understand that my picture, voice, or images of me on film will not appear on marketing materials and/or media sources (including but not limited to: websites, radio, print ads, commercials and newsletters)

I acknowledge this release is firm and final and understand that Cochise Oncology may proceed in reliance thereon.

Patient Name

Patient Signature Date

Patient's Name: _____ Date of Birth: _____

We would like to take the time to learn more about your family history of cancer. The more detailed information we have about you and your family will help better assess your medical treatment plan.

***ANCESTRY:** Are you or a family member of Ashkenazi Jewish decent? Yes or No _____

***GENETIC TESTING:** Have you or anyone in your family had genetic testing for hereditary cancer?

Please check one: ☐ myRisk ☐ BracAnalysis ☐ Colaris Date of testing: _____

		FAMILY HISTORY QUESTIONNAIRE **Please answer ALL 12 questions.**	**FAMILY** Yourself, Sisters, Brothers, Children	**MATERNAL** Mother, Aunts, Uncles, Grandparents, Nieces, Nephews	**PATERNAL** Father, Aunts, Uncles, Grandparents, Nieces, Nephews
Circle each YES or NO			If YES, list family members, cancer site, and their age of diagnosis. Example: *Aunt, Ovarian, dx 45*		
		BREAST CANCER:			
Yes	No	1. Do you have HER2- Breast Cancer and Medicare insurance?			
Yes	No	2. Have you or family members been diagnosed with breast cancer before the age of 50?			
Yes	No	3. Are you a male diagnosed with breast cancer or have a male family member that was?			
Yes	No	4. Do you have breast cancer and have a family member diagnosed with either breast (age 50 or younger) or has prostate cancer that has spread to other body parts?			
Yes	No	5. Do you have triple-negative breast cancer?			
Yes	No	6. Do you have breast cancer that has spread to other body parts?			
Yes	No	7. Do you have three or more family members diagnosed with breast cancer on one side of your family (paternal or maternal)?			
		COLON and ENDOMETRIAL/UTERINE CANCER:			
Yes	No	8. Have you been diagnosed with colon or endometrial/uterine cancer before age 65?			
Yes	No	9. Do you have a family history of colorectal or endometrial cancer? (A family member diagnosed <50 years old or 3 family members)			
		OVARIAN, FALLOPIAN TUBE, & PRIMARY PERITONEAL:			
Yes	No	10. Have you or a family member been diagnosed with ovarian cancer?			
		PROSTATE CANCER:			
Yes	No	11. Do you have prostate cancer and it has spread to other body parts?			
		PANCREATIC CANCER:			
Yes	No	12. Have you or your family been diagnosed with pancreatic cancer?			

Patient signature: _____ **Date:** _____

For Office Use Only:

☐ Criteria not met **Patient offered testing:** ☐ Accepted ☐ Declined ☐ Sample Collected

Reason for Decline:

Provider Signature: _____