SUMMIT
CANCER CENTERS
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

Place Label Here

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age**: _____ ❑ **Male** ❑ **Female** **SS#**: _____

Primary Address: _____

City: _____ State:_____ Zip: _____

Home Phone: ❑ Preferred (_____) _____

Cell Phone: ❑ Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? ❑ Yes ❑ No

Email Address: _____ May we email you? ❑ Yes ❑ No

Preferred Language: _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets:_____

(Internal Use Only)

MRN#: _____

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Patient Name: _____ **DOB:** _____

Primary Care Physician: _____Phone: _____

Referring Physician (if different): _____Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____Phone: _____

_____Phone: _____

_____Phone: _____

_____Phone: _____

Emergency Contact Name:

_____

Relationship: _____Phone: (_____) _____

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):_____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown **Durable Power of Attorney** ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

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Patient Name: _____ **DOB:** _____

Reason for this Visit: _____

Medical History: Check the items that apply to you (current or past)

None	❑	Enlarged Prostate	❑	Leukemia	❑
Asthma	❑	Peripheral Vascular Disease (PVD)	❑	Anxiety	❑
Chronic Lung (COPD)	❑	Diabetes	❑	Problems with Anesthesia	❑
Pneumonia/Bronchitis	❑	Lupus-Autoimmune	❑	Thyroid Disease	❑
TB (Tuberculosis)	❑	Reynaud's Syndrome	❑	High Blood Pressure	❑
Sleep Apnea	❑	Rheumatoid Arthritis	❑	High Cholesterol	❑
Colon Polyps	❑	Osteoarthritis	❑	Atrial Fibrillation (Afib)	❑
Crohn's Disease	❑	Chronic Back Pain	❑	Congestive Heart Failure	❑
Diverticulitis	❑	Osteoporosis	❑	Heart Attack-MI	❑
Irritable Bowel Syndrome (IBS)	❑	Fracture	❑	Heart Disease	❑
Ulcerative Colitis	❑	Stroke	❑	Rheumatic Fever	❑
Stomach Ulcers	❑	Neuropathy	❑	Heartburn/Reflux	❑
GERD/Heartburn	❑	Parkinson's Disease	❑	Heart Murmur	❑
Hiatal Hernia	❑	Paralysis	❑	Irregular Heart Beat	❑
Gallstones	❑	Seizures	❑	Frequent Infections	❑
Cirrhosis of Liver	❑	Migraines	❑	Blood Disorder	❑
Hepatitis A/ B/ C	❑	Shingles	❑	Blood Clots	❑
Pancreatitis	❑	Glaucoma/Cataracts	❑	Anemia	❑
Kidney Stone	❑	Hearing Loss	❑	Bleeding Disorder	❑
Kidney Disease/Failure	❑	Cancer	❑	Drug Use	❑
Freq. Urinary Tract Infections (UTI)	❑	Lymphoma	❑	Depression	❑

Other Medical History: _____

Cancer History:

Type: _____ Date diagnosed _____

Treatment: (type, date, and location of treatment) _____

_____

Treating Physician: _____

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Patient Name: _____ **DOB:** _____

Past Surgical History: *(Please circle and date any of the surgeries and/or procedures that you have undergone)*

Coronary Bypass	Date: _____	Knee Replacement	Date: _____
Angioplasty	Date: _____	Rotator Cuff Repair	Date: _____
Pacemaker	Date: _____	Cataract	Date: _____
Cardiac Valve Surgery	Date: _____	Gallbladder Surgery	Date: _____
Hemorrhoidectomy	Date: _____	Hysterectomy	Date: _____
Prostate Operation	Date: _____	Prostatectomy	Date: _____
Hernia Repair	Date: _____	Appendectomy	Date: _____
Tonsillectomy	Date: _____	Hip Replacement	Date: _____
Mastectomy	Date: _____	Lumpectomy	Date: _____

Other Operations: _____

Social History:

Tobacco Use: *(Present and/or Past)*:

❑ Never Smoked

❑ Quit smoking When? _____ How many years did you smoke? _____yr(s)
How many packs? _____/day

❑ Currently Smoke ❑ Cigarettes ❑ Pipe ❑ Cigars How many packs? _____/day
How many years?_____

❑ Chewing Tobacco

Alcohol History: *(Present and/or Past)*:

❑ Non Drinker

❑ Beer	number of bottles _____per	❑ Day	❑ Week	❑ Month	
❑ Wine	number of glasses _____per	❑ Day	❑ Week	❑ Month	
❑ Liquor	number of glasses _____per	❑ Day	❑ Week	❑ Month	

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other

Household Status: ❑ Lives Alone ❑ Lives with Family ❑ Lives in Nursing Home
❑ Winter Resident ❑ Year-Round Resident

Children: ❑ Yes ❑ No Number _____

Health Maintenance:

Sigmoidoscopy / Colonoscopy: Yes No Date:_____

Findings: _____

Last Mammogram: Date: _____ Last Bone Density: Date: _____ Last Pelvic Exam: Date: _____

Influenza (Flu) Shot: Date:_____ Pneumococcal Shot: Date: _____ Last Shingles Shot: Date: _____

Last EGD: Date: _____ Last Colonoscopy: Date:_____ Last Prostate Exam: Date: _____

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Patient Name: _____ **DOB:** _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:
- ❑ Weight Loss

How much _____
Over what time period _____
- ❑ Fevers
- ❑ Max temp _____
- ❑ Chills
- ❑ Night sweats
- ❑ Fatigue

Eyes:
- ❑ Wear Glasses/Contact Lenses
- ❑ Blurred Vision
- ❑ Double Vision

Ears, Nose, Throat:
- ❑ Hard of Hearing or Deaf
- ❑ Ringing in Ears
- ❑ Enlarged Lymph nodes
- ❑ Chronic Sinus Problems
- ❑ Sore Throat
- ❑ Mouth Pain/Sores

Changes/Difficulty In:
- ❑ Taste
- ❑ Smell

Cardiovascular:
- ❑ Chest Pain/Angina Pectoris
- ❑ Palpitations/Heart Murmur
- ❑ Irregular Heart Beat/Pressure

Respiratory:
- ❑ Chronic or Frequent Cough
- ❑ Bloody Sputum
- ❑ Shortness of Breath

Skin:
- ❑ Rashes or Itching
- ❑ Change in Skin Color or Moles
- ❑ Varicose Veins
- ❑ Skin Cancer

Gastrointestinal:
- ❑ Difficult or Painful Swallowing
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Indigestion
- ❑ Lump or Sensation in Throat
- ❑ Food Sticking
- ❑ Bloating
- ❑ Belching
- ❑ Diarrhea
- ❑ Constipation
- ❑ Rectal Bleeding
- ❑ Black or Tarry Stool
- ❑ Hidden Blood in Stool
- ❑ Excessive Rectal Gas/Flatus
- ❑ Loss of Stool/Fecal Accident
- ❑ Poor Appetite
- ❑ Jaundice

Genitourinary:
- ❑ Kidney Stones
- ❑ Pelvic Pain
- ❑ Incontinence
- ❑ Burning or Pain on Urination
- ❑ Blood in Urine
- ❑ Difficult Urination
- ❑ Men: Prostate Problems

Musculoskeletal:
- ❑ Joint Pain/Arthritis
- ❑ Muscle or Joint Weakness
- ❑ Back Pain
- ❑ Bone Pain
- ❑ Muscle Aches

Neurological:
- ❑ Numbness/Tingling
- ❑ Arm or Leg Weakness
- ❑ Light-Headed/Dizzy/Fainting Spells
- ❑ Tremors/Headaches

Psychiatric:
- ❑ Anxiety/Agitation
- ❑ Depression
- ❑ Crying for No Reason
- ❑ Insomnia
- ❑ Alcoholism
- ❑ Drug Problem

Hematologic:
- ❑ Easy Bruising
- ❑ Gum or Nose Bleeding
- ❑ Blood Transfusions

Endocrine:
- ❑ Heat or Cold Intolerance
- ❑ Excessive Skin Dryness
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Weight Problem
- ❑ Hot Flashes

Breast:
- ❑ Rashes or Itching
- ❑ Changing in Skin Color
- ❑ Varicose Veins
- ❑ Skin Cancer
- ❑ Breast Pain/Lump
- ❑ Breast Discharge
- ❑ Breast Rash

Allergies/Immunology:
- ❑ History of Allergies
- ❑ Chronic Infections

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Patient Name: _____ **DOB:** _____

Family Medical History: Indicate any family members with cancer, blood disease or other disease.

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

MEDICATION LIST

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

Drug Allergies: List all medication allergies

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Are you allergic to:

❑ Iodine ❑ Latex ❑ Shellfish ❑ CT Scan Dye / IV Contrast ❑ Eggs ❑ Peanuts

Other: _____
Type of Reaction: _____

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Patient Name: _____ **DOB:** _____

CURRENT MEDICATION LIST

List all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Ordering Physician

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AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Summit Cancer Centers (SCC/AOP), a division of American Oncology Partners, P.A. (SCC/AOP), to take my photograph (digital camera/video may be used). These photos may then be placed in my SCC/AOP electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

_____

Patient Name (Print)

_____

Patient or Guarantor (Signature)

_____

Date

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REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

_____

_____

Name and address of practitioner

To be sent to Summit Cancer Centers: *(Internal use)*

_____

Address, City, State, Zip Code

_____

Fax/Telephone Number

_____ I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Summit Cancer Centers (SCC/AOP) to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

_____DISCLAIMER: Not signing does not prevent me from receiving care.

_____ _____

Patient Name (Print) Date

_____

Patient Date of Birth

_____ _____

Patient or Guarantor (Signature) Date

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ **DOB:**_____

Please check one of the following:

_____ **I give permission to the employees of Summit Cancer Centers (SCC/AOP), a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)

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Patient Name: _____ **DOB:**_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? ❑ Yes ❑ No

Secondary Insurance Carrier:_____

Name of secondary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? ❑ Yes ❑ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder:_____

Policy#/Bin# _____

I certify that the information provided is accurate. I will notify Summit Cancer Centers (SCC/AOP), a division of American Oncology Partners, P.A. of any changes as soon as they become available. I understand that it is my responsibility to update us of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)

SUMMIT
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FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

Thank you for choosing Summit Cancer Centers, a division of American Oncology Partners, P.A. (SCC/AOP), as your health care provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge our patient financial policies:

- You agree to provide SCC/AOP with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that SCC/AOP will bill your insurance plan or program for services provided by SCC/AOP and you agree you are assigning your right to receive payment or benefits from such insurer or program to SCC/AOP and you are authorizing payment to be made directly to SCC/AOP.
- You agree you are responsible for payment to SCC/AOP of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other health care providers, SCC/AOP will use your personal health information internally and will share such information with your insurance policy and certain business associates of SCC/AOP in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- SCC/AOP owns and operates AON Pharmacy, LLC, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your SCC/AOP physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use AON Pharmacy, LLC and may have your prescriptions filled wherever you choose. However, if you select AON Pharmacy, LLC to fill SCC/AOP-issued prescriptions, then this policy and all other SCC/AOP patient financial responsibility policies will also apply to the items and services provided to you by AON Pharmacy, LLC.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by SCC/AOP clinicians at SCC/AOP's own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to SCC/AOP that results in a surplus on your account (e.g., a credit balance), SCC/AOP may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and SCC/AOP may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of your care a credit balance remains which is not subject to return to your insurer or other payer, SCC/AOP will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

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I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES. A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)

For office use:

_____
Name (Print)

_____
SCC/AOP Employee (Signature)

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CANCER CENTERS
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

MEDIGAP

Only applicable for patients with secondary insurance to Medicare

Name of Beneficiary: _____

Health Insurance Claim Number: _____

Medicare Beneficiary Identifier: _____

Medigap Policy Number: _____

I request that payment of authorized Medigap benefits be made on my behalf to Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) or AON Pharmacy, LLC for any services furnished by _____. I authorize any holder of medical information about me to release to _____ any information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Physician Name

Insurance Name

_____ _____

Patient Name (Print) Date

_____

Patient or Guarantor (Signature)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) facility or by submitting a request in writing to the corporate office at Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP), 9160 Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.
You may also view and/or print a copy of the Notice of Privacy Practices by visiting **AONcology.com/policies/SCC_NPP.pdf**

Date:_____

_____	_____
Patient Name (Print)	DOB
_____	_____
Patient (Signature)	Date
_____	_____
Patient or Guarantor (Signature)	Date

SUMMIT
CANCER CENTERS
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By signing below, I authorize Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized SCC/AOP texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by SCC/AOP under my cell phone plan.

I know that I am under no obligation to authorize SCC/AOP to send me text messages. I may opt-out of receiving these communications at any time by responding with "STOP".

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

PLEASE MARK THE FOLLOWING:

❑ I consent to receiving information via text. I understand I can withdraw my consent at any time.
Text Cell #_____

❑ I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

_____ _____
Patient Name (Print) Date

_____
Patient (Signature)