VISTA ONCOLOGY INC. PS

NICOLE GROUS, MD MIN KANG, MD SARA PRATT, PA LINLI XUAN, MD JOSEPH YE, MD LORRIN YEE, MD

PATIENT INFORMATION

Name: (Last, First, Middle) _____

Maiden Name: _____ Date of Birth: _____ Gender: _____

Social Security Number (**required**): _____-_____-_____ Preferred Language: _____

Race: _____ Ethnicity: _____ Place of Birth: (City, State, Country) _____

Which of our clinics would you prefer to be seen in? (Please circle one): East West Shelton

What are you being seen for today? _____

Has any of your personal or Insurance information changed in the last year? *If NO initial here*_____

If YES please make all necessary changes below

Physical Address (required):

_____

_____

Mailing Address (if different than above):

_____

_____

Phone Numbers (Please circle the one you would prefer we call first)

Home: _____-_____-_____ Cell: _____-_____-_____ Other: _____-____-_____

Email Address: _____

What pharmacy do you use? _____ City: _____

ADVANCED DIRECTIVES

Please circle your responses below:

Do you have a Living Will? YES NO **Do you have a Durable Power of Attorney? YES NO**

Do you have a Medical Power of Attorney? YES NO **Do you have a DNR Form? YES NO**

EMERGENCY CONTACTS

(You authorize that we may contact below persons in case of emergency)

Spouse or Significant Other: _____ Relation: _____

Primary Phone: ___-____-____ Secondary Phone: ____-____-_____ **Initial if you authorize this contact to have access to your health information: _____**

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Name: _____ Relation: _____Primary Phone: ___-____-____

Secondary Phone: ____-____-_____ **Initial if you authorize this contact to have access to your health information: _____**

PATIENT HEALTH HISTORY

Name: (Last, First, Middle) _____

Do you have any allergies? (Circle one) YES NO

If yes, please list and explain reaction:

_____

Medications: Please list all medications you are currently taking, including over-the-counter and vitamins.

Medication	Dose	Frequency	Route	Reason

SOCIAL HISTORY

Marital Status:

□ Married □ Never Married □ Partnered □ Divorced □ Legally Separated □ Annulled □ Widowed

Occupation: _____ □ Full Time □ Part Time □ Retired

Employer: _____ Industry: _____

TOBACCO/ALCOHOL/DRUG USE AND HISTORY

Have you ever used tobacco? □ Yes □ No When/How much (daily average)? _____

Do you currently use tobacco? □ Yes □ No How much (daily average)? _____

If yes, for how long? _____ Do you wish to quit? □ Yes □ No

Have you ever drank alcohol? □ Yes □ No When/How much (daily average)? _____

Do you currently drink alcohol? □ Yes □ No How much (daily average)? _____

If yes, for how long? _____ Do you wish to stop? □ Yes □ No

Have you ever used recreational drugs? □ Yes □ No When/Which ones? _____

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Do you currently use recreational drugs? □ Yes □ No Which ones? _____

If yes, for how long? _____ Do you wish to stop? □ Yes □ No

INSURANCE INFORMATION

Insurance Company: _____ Policy/ID Number with prefix: _____

Group Number: _____Name of Insured: _____ Relationship to you: _____

Insured Person's Date of Birth: _____ Social Security Number: _____-_____-_____

Secondary Insurance (if applicable)

Insurance Company: _____ Policy/ID Number with prefix: _____

Group Number: _____ Name of Insured: _____ Relationship to you: _____

Insured Person's Date of Birth: _____ Social Security Number: _____-_____-_____

Do you have a pharmacy benefit plan? (Circle one) YES NO

PHYSICIAN INFORMATION

Primary Care Provider

Name: _____ Practice Name: _____ Specialty: _____ City/State: _____

Specialty Physician

Name: _____ Practice Name: _____ Specialty: _____ City/State: _____

Privacy Practices and Financial Policy Agreement; Consent to Examine

Are you interested in Holistic Health Care (massage, Naturopathic Medication, ect) to compliment your current treatment plan? ____Yes _____No
If so, may the Holistic Health Clinic contact you? _____Yes _____No

Before signing below, please refer to our Privacy Practices handout, and our Financial Policy handout.
You may request a copy of either document at any time.

I authorize Vista Oncology to leave confidential voice messages on the phone numbers and to talk to the persons I have provided above. I authorize Vista Oncology to use above contact information for billing purposes.
I certify that I, and/or my dependent(s), have insurance coverage through the above named insurance company(ies) and I assign directly to Vista Oncology Inc. all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges, whether or not paid by insurance.
I am aware that I have to provide my insurance information to Vista Oncology Inc. if there are any changes.
I authorize the use of my signature on all insurance submissions.
I certify that all of the above information is true to my best knowledge. If there are any changes, I agree to notify Vista Oncology Inc. as soon as I am able.

Please initial the line next to the following statements, and then sign below.

I consent to be physically examined by my provider if needed. _____ (initial)
I have reviewed and understand Vista Oncology's Privacy Policy. _____ (initial)
I have reviewed and agree to Vista Oncology's Financial Policy. _____ (initial)

Signed: _____ Date: _____

Please Print Full Name: _____

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