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? _____

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 Name: _____ Primary Phone: ___-____-____

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

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

Name: _____Primary Phone:____-____-_____Secondary Phone: ____-____-_____ **Initial if you authorize this contact to have access to your health information: _____** Relation:_____

VISTA ONCOLOGY INC. PS

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

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: _____

Referring 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: _____

VISTA ONCOLOGY INC. PS

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

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

Medical History (Please check all that apply)

□ Lung Disease □ Liver Disease □ Arthritis

□ High Blood Pressure □ Kidney Disease □ Anemia

□ High Cholesterol □ Diabetes □ Abnormal Bleeding

□ Heart Attack □ Thyroid Disease □ Cancer

□ Stomach/Colon Disease □ Stroke □ Other _____

Surgical History (Please list names and dates of all operations): _____

_____

_____

Have you ever had Cancer? If yes, which body part was affected? _____

_____ When? _____

Have you ever received chemotherapy before? □ Yes □ No

If yes, for which condition? _____ When? _____

Have you ever received radiation therapy before? □ Yes □ No

If yes, for which condition? _____ When? _____

VISTA ONCOLOGY INC. PS

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

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 drunk 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? _____

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

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

FAMILY HISTORY

Family Member	Current Age if alive	Age at Death	Illness/Cause of Death (please be as specific as possible)
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Child			
Child			
Other (please identify)			
Other (please identify)			

Women Only

Last Mammogram: _____ Last Pap smear: _____

Age at Last Menstrual Cycle: _____ Number of Pregnancies: _____

VISTA ONCOLOGY INC. PS

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

REVIEW OF SYMPTOMS (Please check all that apply)

General	**Yes**	**No**	**Stomach and Bowels Continued**	**Yes**	**No**
Recent Weight Loss			Change in Bowel Movement		
Decrease in appetite			Constipation		
Fever/Night Sweats			Diarrhea		
Weakness/Fatigue			Bloody Stool		
Skin Rash			**Kidneys and Bladder**	**Yes**	**No**
Head and Neck	**Yes**	**No**	Blood in Urine		
Change in Vision			Kidney Stone		
Cataracts/Glaucoma			Urinary Difficulty		
Hearing Loss			Painful Urination		
Ringing in the ears			Loss of Bladder Control		
Frequent Nose Bleeds			Frequent Urinary Infection		
Nasal/Sinus Congestion			**Bones, Joints and Muscular**	**Yes**	**No**
Sore Throat			Joint Pain		
Lungs	**Yes**	**No**	Back Pain/Injury		
Daily Cough			Gout		
Blood in Sputum			Muscle Cramping		
Wheezing			**Endocrine**		
Pleurisy			High Blood Sugar		
Shortness of breath			Thyroid Problems		
Heart/ Circulation	**Yes**	**No**	**Neuro-Psychiatric**	**Yes**	**No**
Chest Pain			Severe Headache		
Irregular Heartbeat			Tremors		
Heart Murmur			Paralysis		
Ankle/Foot swelling			Convulsions		
Leg Pain w/ Walking			Numbness/Tingling		
Varicose Veins			Sleeping Difficulty		
Blood Clots			Nervousness/Anxiety		
Stomach & Bowels	**Yes**	**No**	Panic Attacks		
Difficulty with swallowing			Depression		
Nausea			**Blood**	**Yes**	**No**
Vomiting			Easy Bruising		
Abdominal Pain			Blood Transfusion		