



THOMPSON CANCER SURVIVAL CENTER / THOMPSON ONCOLOGY GROUP

PATIENT INFORMATION

DEMOGRAPHIC INFORMATION

Patient Name – Last:		First:		Middle:	
If applicable, other name(s) previously on file:					
Address:		City:		State:	Zip:
Phone Number – Home:		Work:	Cell:		
Date of Birth:		Age:	Sex (Circle): M F	Race (Circle): W B Other	
Social Security Number:		E-mail Address:		Marital Status (Circle) S M D W	
Emergency Contact Name:		Phone:	Relationship to Patient		
Work Status (Circle): Full-Time / Part-Time / Retired / Other		Patient's Employer:			
Business Address:		City:		State:	Zip:
Spouse's Name:		Date of Birth	SSN:		
Spouse's Employer	Address:		City:	State:	Zip:

INSURANCE INFORMATION: OUR OFFICE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S)

Primary Insurance:					
Insurance Address:		City:		State:	Zip:
Insured Name:		Relationship to patient:			
Insured DOB:		Insured SSN:			
ID Number:		Group Number:			

Secondary Insurance:					
Insurance Address:		City:		State:	Zip:
Insured Name:		Relationship to patient			
Insured DOB:		Insured SSN:			
ID Number:		Group Number:			

PLEASE LIST OTHER PHYSICIAN(S) INVOLVED IN YOUR CARE OR THAT NEED YOUR RECORDS/REPORTS:

Primary Care Physician:		Phone:
Referring Physician:		Phone:
Other Physician:		Phone:
Other Physician:		Phone:

Thompson Oncology Group

Patient Medical History Form

TCSC60700021 (01/2021)

Patient Name: _____ Account No. _____ DOB: _____

Patient Medical History Form (p.1): Please provide the following medical information to the best of your ability:

Date: _____	Age: _____	List any ALLERGIES TO MEDICATIONS: _____
What problems are you here for today? _____		
Past Medical History:		
1. Please check the "Yes" or "No" box to indicate whether you are experiencing problems with the following:		
	Yes No	
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____
Hypertension (High Blood Pressure)	<input type="checkbox"/> <input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	_____
Cholesterol Problem	<input type="checkbox"/> <input type="checkbox"/>	_____
Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/>	_____
Stomach or Intestinal Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Allergy Problems/Therapy	<input type="checkbox"/> <input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
	Yes No	
Kidney Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Neurological Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____
Anemia,Leukemia,Blood Problem	<input type="checkbox"/> <input type="checkbox"/>	_____
Clotting Excessively	<input type="checkbox"/> <input type="checkbox"/>	_____
Stroke	<input type="checkbox"/> <input type="checkbox"/>	_____
Unexplained Liver Disease/Cirrhosis	<input type="checkbox"/> <input type="checkbox"/>	_____
Other Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/>	_____
2. Please list any operations (and dates) you have ever had (including tonsils & adenoids):		
	Last Colonoscopy _____	
	Last Mammogram _____	
3. Please list or provide a copy of any current medications (and amounts, times per day): We can copy your list if provided. <i>(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):</i>		

Social History: Circle best response(s) and provide details.		
Marital Status:	Single Married Widowed Divorced	
Tobacco Use:	Never Former Current Kind, amount/packs per day _____ Quit _____	
Alcohol Use:	Never Rarely Social Kind, amount per day _____	
Occupation:	Kind of work _____ Retired Date of Retirement _____	
Home Life:	Live alone Live with spouse / children / other _____	
Manages Household:	Self Spouse Other	
Manages Finances:	Self Spouse Other	
Drive:	Self Spouse Other	
Do you have?	Living Will Durable Power of Attorney for Health Care	
List Hazardous Exposures:	_____	
Family History:		
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicated which relative(s).		
	Yes No	
Heart Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Allergy	<input type="checkbox"/> <input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/>	_____
Anesthesia Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
	Yes No	
Stroke or Vascular Disease	<input type="checkbox"/> <input type="checkbox"/>	_____
Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Liver Disease In Family	<input type="checkbox"/> <input type="checkbox"/>	_____
Mental Illness In Family	<input type="checkbox"/> <input type="checkbox"/>	_____
Clotting Problems	<input type="checkbox"/> <input type="checkbox"/>	_____
		Reviewed by: _____

Thompson Oncology Group

Patient Medical History Form

TCSC60700021 (01/2021)

Date ___/___/___

Patient Name: _____ Account No. _____ DOB: _____

Patient Medical History Form (p.2): Please provide the following medical information to the best of your ability:

REVIEW OF SYSTEMS:

1. Please check the "Yes" box **only** if you are **now** experiencing the listed symptom or condition.

		Yes	No		Yes	No
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	recent weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
	fever	<input type="checkbox"/>	<input type="checkbox"/>	decrease in appetite	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>	sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>
	foods	<input type="checkbox"/>	<input type="checkbox"/>	latex or tape	<input type="checkbox"/>	<input type="checkbox"/>
EYES	pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>	vision changes	<input type="checkbox"/>	<input type="checkbox"/>
ENT	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	ear noises	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	problem snoring, apnea	<input type="checkbox"/>	<input type="checkbox"/>
	throat pain	<input type="checkbox"/>	<input type="checkbox"/>			
RESPIR.	cough	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
	change in voice	<input type="checkbox"/>	<input type="checkbox"/>	pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>
	wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>
	abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
	bowel irregularity	<input type="checkbox"/>	<input type="checkbox"/>	rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
	constipation	<input type="checkbox"/>	<input type="checkbox"/>	yellow eyes	<input type="checkbox"/>	<input type="checkbox"/>
	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	dark urine	<input type="checkbox"/>	<input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>
	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>
	increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	increased urination	<input type="checkbox"/>	<input type="checkbox"/>
MSK	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>
	joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	cold/painful hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>
	itching	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE STOP HERE

See attached dictation

Reviewed by: _____



PATIENT PRIVACY AND CONFIDENTIALITY

Patient Name: _____ **DOB:** _____ **MRN#** _____
Mm/dd/yyyy (Office Use Only)

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic test results, or any other situation related to your visit.

How would you prefer to be contacted: (Please mark your choice and provide numbers)

___ Home phone/answering machine: () - _____
___ Work phone / voice mail: () - _____
___ Cell phone / voice mail: () - _____

I also give permission for the Physician/Office Staff to speak with the following people about my care:

Name: _____ Relationship: _____ Phone: () - _____

Name: _____ Relationship: _____ Phone: () - _____

Name: _____ Relationship: _____ Phone: () - _____

___ Release to Patient Only:

Selecting this choice indicates **I DO NOT give my permission** to the Physician/Office Staff to leave messages regarding appointments, lab/test results or any other situations related to my visit/care with anyone other than me.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name: _____ Date of Birth: _____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY ACKNOWLEDGEMENT

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. To avoid disrupting your care and the care of others, it is very important to keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help you remember your scheduled appointments, we send reminders via phone call or text message 2 days in advance of your appointment. If you do not receive these reminders, please let us know so we can ensure we have your correct contact information.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and ensure another patient is able to benefit from your appointment time. We ask that you please give us at least a 24 hour notice when cancelling your appointment; however, the sooner we know you will not be making it the better able we are to ensure another patient can be seen by their physician more quickly.

If you do not cancel or reschedule your appointment with at least 24 hour notice, we may assess a \$35.00 “no-show” service charge to your account. This “no-show charge” is not reimbursable by your insurance company and you will be billed directly.

After the third “no-show” in a calendar year, your doctor and the office manager will review the circumstances of the “no-shows” and may decide to refer you elsewhere for your care.

*I understand the “no-show” policy of Thompson Oncology Group and agree that my account may be charged \$35.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no—show charge. I further understand that if I “no-show” 3 times in a calendar year, I may be discharged from Thompson Oncology Group to receive treatment and follow up care elsewhere.**

Patient/Guardian Signature

Date

** In accordance with TNC rules, TennCare beneficiaries may not be charged a \$35 no-show fee*